DÁIL ÉIREANN

COISTE UM CHÚRAM SLÁINTE SA TODHCHAÍ

COMMITTEE ON THE FUTURE OF HEALTHCARE

Dé Céadaoin, 26 Deireadh Fómhair 2016

Wednesday, 26 October 2016

The Select Committee met at 9 a.m.

MEMBERS PRESENT:

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

DEPUTY RÓISÍN SHORTALL IN THE CHAIR.

Health Service Reform: Representatives of Health Sector Workforce

Chairman: I remind all present to turn off their mobile phones or to at least switch them to flight mode in order that they will not interfere with the sound recording. I welcome our witnesses, those watching and members. For this morning's session, we will engage with representatives of the health workforce, who will outline their vision of health service reform. Health professionals including nurses, doctors and non-medical support staff are the beating heart of our hospitals and community health services, as we know. As Professor Keane emphasised at last week's session, reform programmes need to achieve buy-in from members of the public and staff. This is critical and is the message coming through from a number of the witnesses we have had to date.

Our first session will be with the Irish Congress of Trade Unions, ICTU. We will meet representatives of the Irish Medical Organisation, IMO, at 10.30 a.m. and those from the Irish Nurses and Midwives Organisation, INMO, at 11.30 a.m..

I welcome Ms Patricia King, general secretary of ICTU; Mr. Liam Doran, general secretary of the INMO, Mr. Paul Bell, health division organiser at SIPTU, Mr. Terry Casey, general secretary of the Medical Laboratory Scientists Association, Mr. Eamonn Donnelly, national secretary of the health and welfare division of IMPACT, and Mr. Liam Berney, industrial officer, public sector, ICTU. I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

I understand that Ms Patricia King and Mr. Liam Doran will be making opening statements. I now invite Ms King to make her opening statement.

Ms Patricia King: Congress is pleased to accept the invitation to address the Oireachtas Committee on the Future of Healthcare. The establishment of this Oireachtas committee and the attendant focus on formulating a long-term vision for a reformed public health service is a positive and welcome development. Congress has made a detailed written submission to the committee and my comments and the statement to be made by my colleague, Mr. Liam Doran, chairperson of the congress committee, are based on that submission.

The views expressed in our submission to the committee have been developed in consultation with our affiliated unions. However the Irish Medical Organisation, IMO, has independently developed a strategy for the organisation of the health services. As mentioned by the Chairman the committee will hear evidence from the IMO later in the next session. Members will have noted that in our submission we referred to the fact that over the last three decades there have been several proposals to reform or overhaul the public health service. However, it is clear that real transformational change has not occurred and we continue to have a dysfunctional system in which the perverse incentives that encourage private over public practice

continue to persist. The failure to bring about real transformational change has also had a very demoralising effect on staff within the service. There is strong evidence of a developing and growing culture of restructuring fatigue. It is for these reasons that congress believes that the establishment of the committee presents a real opportunity to begin a programme of reform that should begin with a declaration of intent that, over time, we will move to a universal, fully integrated, single-tier public health service that guarantees access and quality care, regardless of income.

We have argued in our submission that the public health service should be funded through a progressive taxation system. At a minimum, the service should be allocated dedicated funding of 10% of GDP per annum, with a further recognition that significant additional capital spending will be required in some years. It is crucial, as part of the reform programme, that, over time, the State will cease to subsidise all forms of private health care provision. We strongly believe that the development of a network of public, locally-based community health care centres is vital to the future restructuring of the service. For the vast majority of citizens the first point of contact with the public health service will be these centres. These centres should provide an expanded range of clinical and diagnostic services and will lead health promotion campaigns in the communities in which they are based. The network of public hospitals will continue as a vital cornerstone of the public health service but the role of the public hospital will be refocused, with some services devolved to the community health care centres. Vital to reform of the health service will be a move to a team-based approach to patient care which is consultant-delivered and where all hospital staff are respected and enabled to perform tasks appropriate to their qualification levels and competence.

The increase in the number of older people living longer lives is the biggest challenge facing our public health service. This challenge is such that it will require the State to reverse its current policy of privatising elder care and to re-engage as the principal provider of health care services for older people. The incidence of mental health disorders continues to rise and demands a renewed commitment to deliver in full the proposals contained in the *A Vision for Change* strategy published in 2006. Not-for-profit organisations currently provide the bulk of health services to people with disabilities. A small number of highly publicised failures have highlighted the need for better oversight and a focus on quality assurance and patient care. A strategy of providing services in community-based settings must be part of an overall approach to the care of people with disabilities.

The committee must accept that moving to a universal, fully integrated, single-tier public health service presents a number of workforce planning challenges, not the least of which is understaffing. In designing the new system, full regard must be had to appropriate remuneration, reward and recognition systems and other conditions of employment, such that the Irish public health system is ultimately viewed as the employer of choice and is capable of attracting and retaining the most talented staff.

Mr. Liam Doran: It is the view of congress that there is a growing consensus across Irish society that a single-tiered public health service which treats all citizens equally is in the common good for communities and our economy. I remind members that congress represents 750,000 workers and their families and has debated the issue of health extensively over its last number of biennial conferences. We believe there is significant unease about the current two-tiered health system where money buys quicker access to many services. There have been many examples of this. However, despite the many limitations with accessing our public health service, patients report a very high level of satisfaction with the quality of care and treatment

they receive. This high level of performance, once the public health service is accessed, must be maintained as we transition to a public health service which is resourced, structured and available to all citizens equally. Access and equality must be the two measures against which progress is measured. Against this background congress wishes to stress that the transformational change required must be commenced against a number of guiding principles. These include the point that the change to a single-tiered, universally accessible public health service will require far more than a decade. Moreover, the change process must involve a long-term multi-annual commitment for the provision of ring-fenced core funding for the public health service at a minimum of 10% of GDP per annum. In addition, there will be a requirement for a significant capital programme to improve existing infrastructure and provide for new services and all funding should be provided through a system of progressive general taxation with a declaration that the State will, over time, cease to fund or to subvent any form of private health care provision. This will require the phased elimination of all tax reliefs for private health care insurance and direct subventions, that is, to existing private nursing homes. Another principle of the transformational programme must be that all existing public health services are maintained and, where necessary, enhanced until the alternative models of service, with much greater emphasis on community-based services, are established and fully operational. The programme must also lead to a simplified, integrated and readily understood organisational structure with clear lines of accountability and transparency and the single-tiered public health service must also be an employer of choice, offering all staff the opportunity to utilise their skills and talents in an environment which encourages innovation, autonomy and excellence.

On primary care, a cornerstone of a new health service must be universal eligibility for all health services, beginning with primary care services, provided by directly-employed health professionals. Staffing should be on the basis of seven-over-seven opening and centred on a team approach. The public must access the full range of health professionals who can cross-refer from one colleague to another based upon the needs of the person presenting for support or care. There can be no artificial structural barriers to a fully integrated primary care service. Such services, available on this seven-over-seven basis, must be provided on the basis that they can offer sufficient diagnostic and other support services so that the majority of persons attending can have their needs met without referral to the hospital or secondary care service. The shift to primary care will require, in addition to investment, a massive reorientation, not only of health professionals and staff but equally, the public. In that regard services must be capable, in a seamless fashion without lines of demarcation or limitations to access, of ensuring all health professions are fully utilised; chronic diseases can be managed away from the acute hospital; vulnerable people can access care, advice, support and guidance near their home; and significant investment in managing lifestyles to maintain positive health. It must be noted and accepted that a public health service must be enabled and resourced to promote the maintenance of good health within the community and not just be left to deal with ill-health and poor lifestyles.

On acute hospitals, an immediate requirement within our existing public health service is additional acute beds in a number of locations across the country.

As we indicate in our written submission, the latest OECD bed-to-population ratio confirms that Ireland, at 2.8, is significantly below the international norm of five beds per thousand of population. In essence, we have currently the perfect storm of too few acute beds to cater for demand, with wholly inadequate primary care services, which might, if they were resourced, provide a viable alternative to hospital care. In the context of a major investment programme to deliver the required additional acute beds, many of which can be five-day or day beds to reflect changing models of care, we also need to transform the role played by senior clinical decision

makers, that is, consultants, who should be employed to work exclusively in our public health service.

The transformation programme, which should begin immediately, must see consultants on new contracts rostered over an extended day, on a seven-day-week basis. This will in turn require a significant number of additional consultants in the core specialisms of medicine, surgery, paediatrics, obstetrics and emergency medicine. While moving to this consultant-delivered service with less reliance on non-consultant hospital doctors, there must be a significant reconfiguration of the roles played by other health professionals to optimise their contribution to patient care. This, as we have said regarding primary care, must involve more autonomous roles, cross-professional referrals and greatly enhanced team working.

In the context of structures, congress broadly welcomes the establishment of the seven hospital groups and the potential it offers to provide optimum patient pathways, minimise duplication and streamline decision-making. However, congress also believes, in the context of commencing this transformational programme, no existing acute hospital service can be discontinued unless or until an alternative service which enjoys the confidence of the public is readily accessible and available.

In the context of this country's demographics, we face two major challenges regarding the provision of services and care to older people arising from the following: it is a fact that the number of senior citizens will steeply increase over the next 25 years. There has been a 21% increase in the number of persons over 65 since 2010 alone. Linked to this increase in the number of older persons will be a significant increase, estimated at 4% to 5% per annum, in the number of people presenting with multiple chronic conditions requiring ongoing intervention, care and support. At this stage, I remind the committee that the number of people attending emergency departments has gone up by 5.3% this year to date. The vast bulk of those are frail elderly, and this increase will continue unless we provide alternative pathways for those people to present to deal with their changing chronic conditions. Regardless of how effective we make primary care services, it is a reality that long-term care will be necessary for significant numbers of our senior citizens. In that regard, congress is absolute in its belief that the State must declare that, over time, it will return to being the main direct provider of long-term residential care for older people. This will require significant State investment in terms of physical infrastructure in residential surroundings. All moneys currently spent on direct State provision to private nursing homes, which can be estimated at up to €20 million per week or over €1 billion per annum, should be phased out and redirected into public direct provision.

Regarding mental health, congress must begin by highlighting its concern that both budgets and services have been severely cut in recent years. Furthermore, it appears that funding earmarked for mental health has for various reasons been utilised in other areas of our public health system. As recommended by the WHO, it is imperative, as we transition to a single-tiered service, that funding for mental health be set, at a minimum, at 12% of the total health care budget. In addition, service provision, as part of the transition, must be integrated within primary care. It must be accessible by the service user on a seven-over-seven basis, and in major urban areas on a 24-7 basis, through dedicated staff in major emergency departments. I think we all know the problems mental health is presenting at the moment and the hidden hurt and damage it is causing. Congress also believes that, in properly resourcing mental health support services, necessary funding must be provided for preventative programmes. We must also recognise that a wider range of professional staff, including teachers - in schools and colleges - as well as all health professionals, must have training in the identification of early signs

of mental health difficulties.

Congress asks the committee to recognise, acknowledge and accept that funding for disability services in this country has been subject to major cuts over the last seven years. This has been done in a way which has had a major impact upon the quality of services available and the range of services that can be accessed in different parts of the country. This negative development has also been exacerbated as many services are provided by a range of entities which, while independent, rely almost exclusively upon State funding - section 39 agencies, for example. It is the view of congress that all disability services should be provided through direct provision, with directly employed staff and in a manner which ensures that access to necessary supports is available regardless of income or location. In making this point, we acknowledge the excellent work done by many not-for-profit organisations. However, in order to ensure equity of access and service provision, congress believes direct provision is the model for the future. In the context of moving to direct provision, there must also be a continuing process of integration into community-based living and working opportunities for the disabled person as we minimise the need for more traditional residential-type living environments. This must be provided for in the capital development programme referred to earlier.

Regarding miscellaneous matters, congress is acutely aware of the need for openness, transparency and accountability from those who manage and deliver services to the citizens of this country. That is why congress supports strong regulation to govern how all professionals practise. For the public to have confidence in those providing care, it is essential that clear regulatory standards apply and are seen to apply. Congress also recognises that any such service must be subject to constant review and examination by a wholly independent inspectorate.

Congress believes that an absolute cornerstone of a world-class, single-tiered, accessible health service is the employment of highly motivated health professionals and support staff. This must be within an environment in which innovation is encouraged and staffing levels, as determined by an evidenced-based approach, are maintained and guaranteed. In that regard, the transformation programme we all seek must recognise that our health service in the future must provide excellent remuneration, reward and recognition systems. It must also provide continuing development programmes so that staff are fully equipped for the ever-changing environment which will inevitably exist within every health service.

The establishment of this committee and its report can, in the view of congress, be an absolute watershed moment for this country and its approach to the provision of health services to its citizens. In that context, congress believes that this committee should clearly state that an overarching goal of this process, in the interests of communities and the economy, is a move to a universal, fully integrated, single-tiered public health service that guarantees access and quality of care regardless of income. This can only be achieved by guaranteed minimum funding in addition to significant capital investment, which must be removed from the uncertainty of the political, electoral and budgetary cycles. Congress recognises this is not an easy challenge, but it must be obvious to all of us that declaring a budget for the health service in October for the coming year makes forward planning all but impossible. The reality of our two-tiered health system, with its illogical and contradictory incentives for key players, makes the journey to a single-tiered system all the more difficult. That is why congress believes the change process will take at least 15 years and will require significant, sustained and increased investment. Congress also believes there is no option or alternative to this reality when one takes into account existing contractual arrangements, existing service limitations, growing demand, changing demographics and societal expectation with regard to treatment. Congress also believes that this

journey will require clear, determined and unambiguous leadership across the political system and within the health service itself. The goal must be that when we reach 2030 the citizens of Ireland will live in a country which promotes the maintenance of good health but which responds to ill health in all its forms with efficiency, effectiveness and professionalism, regardless of socio-economic status or where one lives. This is a demanding objective but one that can, and must, be realised.

Chairman: I thank Mr. Doran. Is it all right with him if we publish both witnesses' opening statements? They were very comprehensive statements. I invite members to contribute and ask questions. I ask the witnesses to bank the questions; we will take members in groups of three.

Deputy Josepha Madigan: I thank Patricia King and Liam Doran for their statements and for appearing before the committee today to share their thoughts and views. It is very important that we hear those thoughts and views and listen to what they say because of the positions they hold and the influence they have.

I see they call for a dramatic overhaul of the health system, which is laudable in itself. I am playing devil's advocate in that I am asking particular questions so that we can tease out issues for the benefit of the committee. Reference was made to a 10% of GDP spend on health care, restructuring fatigue and the need for a timeline of greater than ten years in terms of implementation of a plan. Is the proposed 10% spend workable given the already high tax burden borne by many families over the last number of years? In regard to the timeline and given changes in technology and medical science, would a further increase in the timeline be required at a future stage? In regard to the proposed centralised health system, my understanding is that there is no room within that for private health care providers, non-for-profit providers and community-based health initiatives. There must be some way we can learn from the experiences they have had or to in some way include them in the system. In other words, there must be some leverage to use their skills and services. It would be detrimental to leave them completely out of the picture.

I note the comments regarding senior citizens and I agree that the State should be the main provider of care for them. This is going to be a problem area into the future. The issue of people living for longer and the increasing number of frail and elderly people living in our communities is one that this committee will have to address. I agree also with the witnesses' comments regarding mental health. It is important the committee would also take note of them.

Deputy Louise O'Reilly: I thank the delegates for attending this meeting. Mr. Doran mentioned that we need to ensure that all health professionals are being fully utilised. That would suggest that currently they are not, with which I agree. However, perhaps he would elaborate on the untapped expertise and resources currently not being utilised. I accept there will be challenges in terms of how we can best make use of resources because that requires a certain amount configuration and I imagine there is restructuring and reconfiguration fatigue in the system.

I am interested in hearing the witnesses' views in regard to how much value we get from the private sector for the services that are provided, on which issue I am sure the witnesses are aware I have my own views. For example, we know that €19 million was spent on private ambulance services over four years, €6.3 million of which was spent in one year. I believe we have people who could and should be providing that service publicly. There has been much discussion at this committee about the big bang approach versus incrementalism, which is, possibly, more achievable. How soon could we be ready for the type of massive transformation that we

all know is necessary? In regard to incrementalism, we have discussed whether it is possible to reform the system piece by piece starting with the community system, followed by the hospital system and so on. I am interested in hearing the witnesses' views on how that would work, if it would work or if we should be massively aspirational and do what was done in Britain with the NHS? In other words, should we put the necessary legislation in place and move ahead or should we take the incremental approach?

Deputy Billy Kelleher: I welcome the witnesses and thank Ms King and Mr. Doran for their presentations and the more detail submissions made to the committee. I have a couple of questions which seek to tease out how we move from where we are in terms of developing a strategy to implementation of what we all hope we can achieve at some stage, namely, a universal public health system with access based on clinical requirement. We have to live in the world. That type of system will have to be funded by the taxes of the members of ICTU. We must get to a stage where we have a sustainable health system. Ms King referred to funding equal to 10% of GDP. While 10% is an arbitrary percentage figure, when GDP is growing rapidly, as the case may be, hopefully, in the future, or shrinks rapidly, as was the case not so long ago, the result would be a system that is not underpinned on a sound financial basis in terms of longer-term planning. I would welcome more clarity on whether the proposal for a 10% of GDP spend is an aspiration or whether the spend needs to be more clearly defined.

In regard restructuring fatigue, the HSE was established in 2004. It then hit the sands in 2008 in terms of the financial melt-down and cutbacks to services. One could argue that the HSE did not exactly hit the ground running and was quickly in huge difficulty in terms of financial resources. The nearest we have to a public health system is the HSE, in aspiration at least. The broader issue that we need to address is the value for money provided by the HSE and what it has up to now delivered. My questions for the witnesses are primarily around the issue of staffing levels. Has a comparison been undertaken of staffing levels in other countries in terms of grades and professional competencies? Very often, I find that when comparing figures I am not comparing apples with apples, but apples with oranges. People are flexible in their views in terms of what exactly is a comparator. In terms of the research by ICTU and its effort to come forward with a logical proposal in terms of how we develop a universal health care system, does it have statistics based on comparisons, bearing in mind that some of our public health system is crossed with a private health care system? In other words, what are the statistics for the public health system when one strips out the private health care system?

Mr. Doran said that in terms of cost of delivery one of the biggest challenges facing us is that of demographic change, life expectancy, co-morbidity, chronic illnesses and diseases, people living longer but also living with chronic diseases and neurological illnesses and so on. In this regard he said that the public health system should deliver all of the care for elderly people, over a period of time. Is there any cost to support that or is that an ideological view? Mr. Doran might elaborate on whether the public health system can deliver health care cheaper and more effectively than the private system, taking account of how this is currently done through the fair deal scheme.

On hospital capacity, there is no doubt but that there has been a stripping out of beds in our acute hospital setting in particular. It was stated that we have now arrived at the perfect storm in terms of poor supports in the community in primary care, life expectancy and demographic changes, the flip-side of which is that everybody ends up in our emergency departments on trolleys. In that context, where would ICTU start if implementing a plan? Would it start at primary care level by frontloading primary care investment initially, would it favour transformation of

the whole system overnight or, in the context of a 15-year timeframe, what would be its priority to alleviate the immediate problems facing our acute hospital system, emergency departments and people on trolleys?

Ms Patricia King: I will respond to some of the questions and my colleagues, all of whom are involved in different areas, will respond to others so as to ensure we give the best possible responses.

Chairman: I would ask everybody, including members, to be as brief as possible because there a lot of members hoping to get in.

Ms Patricia King: Regarding Deputy Madigan's comments on the 10% of GDP and the taxation system, fundamentally, this is down to Government choice. As we have described in the submissions made to the committee, which we will not repeat, it is about choices. We are very clear that the private health system should not be subvented by taxpayers' money. If one wants to build the universal, single-tiered system, one makes choices to do so. At the moment it seems that 70% of the health service is funded by Government. According to the figures for 2014, that is about €13 billion. We are clear, as we said in the submission, that we should not have a system that has perverse incentive to uphold the private system. Anybody is fully entitled to make a judgment that this is an ideological and aspirational position and so on, but the people in power who make decisions must make the choices. The choice in the health sector at the moment is that if one has money, one gets cared for quickly, but if one does not have money or if one's income level does not lend itself to care, one waits. That causes people on lower income scales to die or to spend a longer time being ill than somebody who can buy health care. That is a perverse system and is down to the decision of the political establishment and policy-makers that that is the kind of health care system they want. I have no doubt that the politicians who must make those decisions, particularly those in power, must make decisions about all the other leans on the taxation system and on public funding and so on, but that is really what it is down to. Even if we just take Europe, other European countries have made different decisions, which is why, skipping briefly to Deputy Kelleher's question about whether we have facts or statistics, it would be desperately difficult to get anywhere other than to start comparing apples with oranges when one makes comparisons with the Irish health system because it is unique in the way it treats its citizens in terms of inequality. There is a much bigger preponderance of equality in the French and UK systems than there is in the Irish system.

I will leave the issues about medical science and so on to my colleagues. I will deal with an issue Deputy O'Reilly raised. She mentioned the ambulance service. There are two aspects to this. There is either a myth or a belief that some policy-makers have that once they outsource something, it will be cheaper. If one looks even across the water, very recently many studies have been done on this. Great Britain is now starting to go back to insourcing. We are usually about five to six years behind such thinking.

On the question of outsourcing, first, this country does very little monitoring of what happens to its money when it puts it out to the private sector to spend. Second, Paul Bell, my colleague, and I are very familiar with the national ambulance service. I am very familiar with the ambulance service provided through the Dublin Fire Brigade in the city of Dublin and the surrounding counties. Mazars did an in-depth report, in which I was involved because I represented the firefighters for a number of years. They would say the service, which is provided on a 24-7, 365-day basis and is integrated with the fire service, is beyond doubt and beyond comparison the cheapest. There has been a plethora of both public servants and luminaries in the private sector who want to get their hands on that service and have it outsourced. Given that

the firefighters provide a service *par excellence* to the citizens, as does the national ambulance service, very few would be able to replicate the excellence of that service, but there is a push all the time. When one examines in-depth that segment of the ambulance service, one will see there is no way the private sector, which is in it to make a profit, could replicate the level and standard of service being provided at that price level. Therefore, over many years, in my positions both in SIPTU and now in Congress, I have advocated insourcing. This privatisation and outsourcing is certainly not all it is cracked up to be, and the State does very little in the order of following the money and seeing what value taxpayers get in this regard.

Restructuring fatigue, in my judgment, is a very big issue in the HSE in particular. Throughout the staff, regardless of grade, whether one earns at the very top end or the lower end of income levels, restructuring fatigue leads to the belief that the restructuring will be an ongoing feature. This is a big challenge that this group will face for any transformational propositions it faces because when one wants a change of staffing in any organisation, one must win hearts and minds. One has a major mountain to climb when restructuring has taken place about 101 times and has not worked. The people supposed to be delivering the service will say it has happened before and that they have no faith in it. Winning the hearts and minds of workers is a big problem for the health sector. Over decades I have walked into many canteens and many workplaces and had discussions there with workers. It does not matter how good or wonderful the manager is or what good ideas he or she has because the workers will have heard it all before.

Another point is that to make restructuring work, the people, both those at the policy development level and those charged with implementing it, must have confidence and show confidence that what they are proposing will actually work. They must believe it will work. That is not the case at the moment. They do not believe it will work. They do not know whether it will work and they shift from one big idea to another. When one pushes it and asks them whether they think it will work, they do not know because the basic, fundamental principles such as, for instance, the perverse incentive, are usually not changed. The perverse incentive will usually be in the new plan. Unless one grasps the major aspects of transformation that must happen and shows willing from the top to the bottom that this will happen, people will just see it as another restructuring. That is a big challenge for this committee and for us on the ground who work with the people who work in the health service. The health sector is 95% unionised so, from that perspective, we are in there all the time listening to such concerns. At that I will hand over to my colleague.

Mr. Liam Doran: I will try to fill in the gaps Ms King has left. Regarding the comments about funding, let us have a clear debate about this. Ireland currently spends 10.1% of its GDP on health, 7% through public and approximately 3% through private, out-of-pocket expenses, which the State subsidises through tax allowances and tax rebates for health insurance. Therefore, those who can afford to pay get better access to the health service. That is irrefutable. It is as straightforward as that. In the context of working out what we want to spend, Congress says we must tie up the money in direct public provision. If one wants private health care, one can still have it, but the State will not subsidise it. There will be fully universal access to health care, whereby everyone is treated equally and no one is asked whether he or she has health insurance or is on a medical card. The latter would automatically put one in the old dispensary model whereby one goes in one door and the other door. That is the reality, only we will just dress it up in nice clothes. That is where we are.

The question of private practice will always be there. The NHS is lauded. In the UK, 12% of health care takes place in the private sector, so private practice is there, but people choose to

avail of it and fully meet the cost and so on.

Regarding the full utilisation of all health professionals, let me be very blunt with the committee. Members are right that organisational fatigue has set in, but there has not been reform in the front line over the last ten years. The number of hospital weekend discharges has not changed. We talk about seven-day working of hospitals; it has not changed. I faced the CEO of the Health Service Executive in 2007, Professor Drumm, who accused our people of elder abuse, because the people I represent were not prepared to carry out first-dose antibiotic IV fluid-balance phlebotomy duties in care of the elderly and so they were being sent back to an acute hospital to have an acute episode of care managed. That was a grossly unfair charge. Congress has been sitting waiting for the HSE to engage in that very thing for the past two years and they will not talk to us because of the siloed budget structures that exist in the HSE. In social care, to keep people in a long-term home while providing first-dose antibiotic, a blood transfusion or an IV transfusion will cost the social care budget money. It will save the acute hospital budget money, but that is a different budget. That is the level of myopic structuring we have now.

On reforming health services in the community, why can a public health nurse, who knows the households in the area, who knows the support structures in families and who identifies Mr. Murphy or Mrs. Murphy as having a deterioration - maybe the chest respiration has gone up, there is pyrexia when the nurse visits the home and so on - not be empowered to prescribe within protocols automatically without having to refer to a GP? Public health nurses have done a four-year undergraduate programme, a one-year postgraduate higher diploma, have a minimum of two years' experience and will also have done a prescribing programme to get there. If people are not safe in their hands, they are not safe in anybody's hands. They are willing and able to take that on board. I am also talking about community RGNs. We should also have that kind of protocol in care of the elderly. That is what we mean by health professionals not being fully utilised.

An OT should be able to refer to a public health nurse. A public health nurse should be able to refer to a dietician. A dietician should be able to refer to a physiotherapist. All those things should be able to happen within the team environment without, as is current practice, having a GP as a trigger. GPs are an essential part of the team, but when the condition changes there needs to be a new diagnosis, not when we are dealing within agreed parameters the ebb and flow of managing a chronic condition. That is what we mean by underutilising. That also requires a mindset of the public because we have a medical model of care here where, to a certain extent, if I go to the GP and do not get a prescription for a tablet or a referral to a hospital, the GP was no good because he or she did not listen to me. That also needs to change. That is what we mean by fully utilising health.

On the big bang or incrementalism, with the contracts that exist at the moment - people absolutely have a right to have those contracts honoured - I do not think Ireland can do a big bang because we are not starting in the same place as Britain was in 1948 or whatever. We have to respect people who have contracts. However, we have to replace all those contracts incrementally with public-only contracts so we shift over that 15-year period. If existing contract holders want to move into the new model that is brilliant, but they cannot be made to and have to be respected. A certain court case is being taken over a certain grade of medic. How much will that cost? That is a contractual obligation; that is life. We would love to do a big bang, but we are not starting from that place.

I agree with Deputy Kelleher on staffing levels. In this country we are unwilling to accept best practice as determined by evidence already found in other countries, whether we call it

nurse-patient ratio, midwife-birth ratio. Earlier this week we saw a shortage of consultants in the cardiac area and that negative impact. Our staffing must be evidence-based. In a public health service, if we want stable consistent care, whether I am in Bloody Foreland in Donegal or Rosslare in Wexford or Skibbereen or Dundalk, we need to have norms of staffing that are consistent and are maintained. They can be a cousin of the pupil-teacher ratio if one wants to make that comparison. That is how to guarantee consistent care. A hospital should not be staffed on the basis of having a Minister in the right place. They should be staffed by virtue of evidence. That evidence should be determined annually by the front-line manager and we are working on that. The good news is that in my little area there is a task force on nurse staffing. There is a maternity strategy which clearly identifies obstetric and midwifery-to-birth ratios. We can do that. The evidence is there internationally. Part of the transition would be to standardise and normalise. However, that also requires everyone to clearly understand it is a team game. The consultants, NCHDs, nurses, midwives, health-care assistants and allied health professionals, all have a role in a standardised structural approach based on evidence. The best places for outpatient outcomes are the ones with patient ratios. California, New South Wales and Victoria have the best patient outcomes, but it requires a significant investment.

On demographics and the cost of the fair deal, I do not believe anyone understands that we are standing on the edge of the precipice when it comes to the demands for elder care. It is not just a question of them getting older but their co-morbidities will increase, as will their expectation of treatment. That will only come the way of the health service. We have to have regard to the pension situation. Even if we left it as it is, how many of those will be able to afford private health care? They will all come through the public door, which will need to be widened and prepared for that. We have suggested 2030 because we do not believe it can be done in a year or two years. Equally it cannot be limited by the electoral cycle or politics.

Where do I start on health capacity? Let me just provide the committee with some short statistics.

Chairman: I ask Mr. Doran to keep it very tight as many others wish to contribute.

Mr. Liam Doran: In September 2006, a total of 3,724 people were admitted for hospital care, for whom no bed was available. In September 2016 that number had risen to 7,551. That requires immediate attention. That is not 50 beds for every hospital in the country. That is a targeted immediate capital investment programme in the nine most challenged hospitals. That must be an immediate measure, not just because we say it or it is politically expedient, but because patients need it.

Deputy Pat Buckley: I thank the witnesses for their presentations this morning. I also thank them for their honesty and frankness. Obviously morale within the system is at an all-time low. Mr. Doran mentioned that if a nurse has the competence to write a prescription, it should speed things up, so that is covered. I would note as a red flag issue the 5% increase in the admissions of the elderly, which will continue. Should this be a massive issue of importance for Government and not just this committee? If hospitals are clogged up, other patients will be pushed behind.

On mental health and the issues with schoolteachers, how should that be addressed? Would there be contractual issues with that? I view this from the point of view of nipping things at the bud. As Mr. Doran hit on the existing contracts, the big bang theory is squeezed into a kind of small bang theory.

On accountability, leadership and confidence, if there was one thing that we could implement tomorrow, what would that be?

Deputy Alan Kelly: I thank the witnesses for their presentations. It is the first time I ever said this and I do a lot of committee work but I do not think there was anything I disagreed with. In this Oireachtas there are two health committees, the normal health committee chaired by Deputy Harty and this committee under the chairmanship of Deputy Shortall. This is a once in a generation, possibly once in a lifetime, opportunity to finally sort out the health service. Ultimately it is an ideological debate. The report we will produce, on which we have a timeline, will be fairly high level. It may have some indications with regard to a plan, which I will deal with, but it will be fairly high level. I hope I am not speaking out of turn but I believe most of us will come to a consensus in terms of what we will decide about a single tier system where services are free at the point of delivery but we will have to deal with the questions, challenges and pressures that will arise in terms of how we will fund that and the consequences of saying what was just said about private health insurance, for instance. That is an issue on which we will have to bring the public with us, and the witnesses in terms of supporting it, because as I said in the Dáil last week, if we are ever to sort out the health service, morally, we cannot allow what is happening to continue where an elderly woman can go into a public emergency department and wait on a trolley for two or three days to be admitted when 100 yd. down the road an executive of a company can go into a private version of the same hospital on the one campus and be treated immediately. That is just not equitable in 2016.

With regard to how we do this, my colleague spoke about the big bang approach. I agree with Mr. Doran that we cannot take a big bang approach. We have a mandate for ten years but we should not get too stuck in that. Over the coming years we will have to phase in the changes with regard to this ideological thought in terms of how we will turn that around, phase out the contracts Mr. Doran spoke about, ensure there is adequate funding and prioritise the different areas. I can see an avalanche coming towards us with regard to care of the elderly. Given that soliloquy, my first question is on the process we will go through in producing a report on the future of health care over the next ten or 15 years. In terms of stopping that ship, turning it around and facing it in the right direction, what areas do the witnesses believe we should prioritise across the health service, given that we will have written a report for which I hope there will be political support on the basis of what I just said. Which areas do we prioritise, in what order and to what timeline? It is a difficult question but I would appreciate an answer to it.

Second, I presume that turning around primary care is an absolute priority given the costs associated with treating elderly people in acute care versus treating them in their homes, etc. How quickly could we have the capacity, working with the unions' members, to turn that around and create a primary care service across the country that is consistent throughout all its services? We know what we want but if that was a priority, in what timeframe could we turn that around?

I have two final questions. First, we spoke about restructuring fatigue, seven hospital groups, nine community health organisations, etc. That does not make sense to me. I had a discussion in Clonmel recently with one of the authors and I told him it did not make sense to me. There is restructuring fatigue. How can we bite through that, so to speak? It is not just about this committee producing a report stating that we need this structure because I am not sure anyone would believe that. How can we change the discourse on that to ensure we bring people with us on it? There will be organisational change but it should not be just a top-down approach.

I would like a brief answer to my final question, which concerns the witnesses' members. We had a presentation some weeks ago on the use of technology to facilitate the witnesses'

members with regard to their work. How bad is that? From what I see, it is fairly bad. With regard to facilitating the work the witnesses' members have to do on the ground, all of us are aware of the issues to do with staffing but we also know that those members are not being facilitated through archaic systems that are in place.

Deputy Michael Harty: I thank the witnesses for attending. As they are aware, the purpose of this committee is to devise a single tier health service based on need rather than the ability to pay. I want to cover two areas, namely, privatisation and work practices. Mention was made earlier to frail elderly patients with multiple chronic conditions being consumers of the health budget. Nursing homes with a large number of frail elderly patients are not resourced to care for elderly patients who develop a deterioration in their illness. Consequently, they end up in casualty departments. In the same way, community services are poorly resourced in terms of home care packages and services, resulting in frail elderly people ending up unnecessarily in casualty departments. Is the privatisation of elderly care, both residential and community, going in the wrong direction? That is the way we are going; we are privatising it. Does that need to be reversed?

With regard to work practices, are there demarcation barriers within the health service unions which are inhibiting change? Is there room for reform and more flexibility in that regard?

Chairman: I thank Deputy Harty for his brevity.

Ms Patricia King: I will ask my colleague to deal with the earlier questions.

Mr. Paul Bell: I will be brief. It is unfortunate that Deputy Kelleher had to excuse himself because I want to touch on private sector involvement. It is not an ideological position. Much of what is happening with regard to privatisation is reactionary because we could not recruit people in the various skill sets and because there was a head count moratorium. For instance, the issue of agency staff is reactionary. This year, over €330 million will be spent by the Health Service Executive on agency staff including nursing professionals, medical professionals and, as mentioned earlier, non-medical personnel. That is reactionary; it is not value for money.

Deputy Louise O'Reilly referred to the ambulance service. An element of the private sector is taking advantage of the chaos the national health service has to respond to in order to provide services while somebody else is keeping an eye on the books and saying we did not have to recruit those people to provide that service.

Deputy Harty asked about demarcation and so forth. We have people in the community who want to do more. For instance, he referred to home care packages. We have people providing home help services. That is sometimes described in the community as a cottage industry. It is not. We have personnel who are described as non-medical people providing key services and supporting their professional colleagues, and our members want to be placed in a position where they can do more.

The other area is health care assistants. The health care assistant groups and the multi-task attendant groups want to be allowed to do more and develop their role in support of the nursing professionals, doctors and other allied health professional groups. Those are the key issues we believe we can address.

Deputy Buckley asked about the one action we can take now. Everyone in this room understands there is a massive issue about the care of the elderly. It is as if we are drifting from crisis to crisis in that regard. Obviously, value for money for the taxpayer does not mean the

services are surrendered to other groups that say they can provide services, which they cannot provide. There has to be a clear understanding that the public health service must be the lead care provider. Following that, if there is ancillary work or additional work, a discussion can take place on where that fits in because at present it is reactionary.

We need to stop the reactionary issues with regard to deployment, recruitment and retention of staff. That can be done. In terms of the €330 million bill for agency staff, that can be stopped by immediately adopting a plan to invest in the training of not just professional staff but also the group the Deputy referred to as non-medical staff. At present, the HSE is paying for almost 900 whole-time equivalents in the health care assistant grade, which amounts to between €60 million and €65 million. That is not good value for money or a good investment. Members of the ambulance service have had to threaten industrial action in recent times for the HSE and the Department of Health to invest in their service. In other words, investment is required over the incremental period of the next three to five years to bring it to a level where it can respond to the growing needs of communities.

The focus must be on investment in the care of the elderly and in care in the community, as well as in those services and people who support that. The general secretary, Ms Patricia King, has made it quite clear that there is no silver bullet for this stuff. If a ten-year plan is adopted by the Oireachtas it must include the understanding that every cent available from the public purse must be invested in a public health service that can deliver over that period. Short-term solutions will not work for us. That has been proven by our neighbours in the United Kingdom. All the short-term, reactionary responses to long-term issues end up failing, costing more money in terms of value for money and losing staff. The National Health Service, NHS, in the UK is still short of nursing professionals. It continues to come to this country to try to recruit nursing and other medical professionals.

Mr. Eamonn Donnelly: I will be brief. The questions are linked to a chain of answers. I will add a point on one of the questions Deputy Kelleher raised earlier and with regard to what Mr. Liam Doran said about nurse and patient ratios. We agree with all of that but there is a populist view that our health service is bloated with managers, administrators and the like. I have the census with me. If we are discussing staffing levels we should not take the easy default position that it is bloated with managers. Managers currently account for 1.33% of the entire staff. That is in line with the NHS model, according to the Minister's research. The total percentage of administrators, right down to the people who compile charts for doctors and consultants, is approximately 15%. If we are going to get into a debate about beefing up staff numbers, I wish to make it clear that it is not just a question of us having too many managers and administrators.

However, that leads to a chain of thought about managers. Deputy Kelly mentioned the nine CHO areas and the seven hospital groups, which does not make sense to many of us. These managers must manage this. One talks about restructuring fatigue. That is at the heart of it because they are being asked to manage something that, quite frankly, many people do not believe in. They must try to introduce these things on a daily operational basis when there is a complete lack of buy-in from people because they do not know what is coming next. That leads to Deputy Harty's question about demarcations. Demarcations are probably imposed by the system. The cross-referral mentioned by Liam Doran is exactly what I am discussing. Whether it is in nine CHOs, five community areas or whatever, if we could move to community care where there is cross-referral between highly-qualified professionals, such as occupational therapists, physiotherapists or public health nurses, that would remove much of the demarcation. Our people are up for that challenge. The difficulty is the lack of a vision presented to

them and the lack of ability to manage that, because nobody is clear about what the vision is. It is causing a slow-down in the system.

Ms Patricia King: Mr. Liam Doran will address two or three of the other key points.

Mr. Liam Doran: I will do it in reverse with regard to the frail elderly, the privatisation and the way back. In response to Deputy Harty, yes we have a very blunt view that what has happened in recent years regarding the care of the older person services is doomed to failure. The privatisation, the reliance on private nursing homes, the direct subvention to them and so forth will never be able to meet the growing demands that are placed on them. The sub-text of that is that the staffing levels in those nursing homes are not necessarily the best because one is managing, looking for profit and other issues come into it. The issue as well is that we must stop everybody being moved to the accident and emergency department the moment they have a temperature, respiration problem or the like. We must staff the units so they are capable of meeting those challenges, which are predictable challenges in many ways. They are very acute for the individual enduring them but they are predictable to the health professionals who know the area. That is the reason congress is calling for a complete reversal in that area to ensure there is a care of the older person service, whether it is in the home, a long-term facility, a transitional care facility or a rehabilitation facility, that is directly subvented and properly staffed, so the person is kept out of the acute hospital if at all possible. There is also the issue of how we will manage the quantum. It is anticipated that there will be 1.7 million people over the age of 65 years by 2045 in this country. Think about that. There are only 650,000 now. We have that huge statistic coming towards us. Privatisation of the older person service will not work in Ireland. It did not work in other jurisdictions. We must come back up that road.

Mr. Eamonn Donnelly mentioned work practices. There is no point in us appearing before this committee and saying that everybody else must change but we need not. Health professionals must change. We must have different models of care and we must liberate and complement one other. We do not, and cannot, survive on a medical model of care for our public health service. It must be one that is originated by the right person in the right place empowered to do it. That is the reason we are calling for regulation and independent inspection, so one can cross-check all of those things happening all of the time. Nobody has a divine right to walk away from public scrutiny when it comes to health. That is the reason we include regulation and inspection.

What is the one thing we could do now? Mr. Paul Bell touched on that. What we must do now is staff our health service properly to meet the demands being placed upon it. For example, we train 100 public health nurses per year. In the first six months of this year there were 41 fewer public health nurses in the public health service than there were in the service at the beginning of the year, because we cannot replace them. We require massive investment in a training programme for 200 public health nurses per year, at a minimum, and we must increase staff. Mr. Paul Bell is correct about health care assistants and home help personnel. It is not all about high-level consultants, multi-qualified nurses and so forth. It is about the whole team situation and one cannot achieve that, with respect, by paying the minimum wage to people providing home care. In many areas of this country, home care cannot be provided, even though there is the money, because the service cannot get the staff. The end product is that Mr. or Mrs. Murphy sooner or later ends up back in the emergency department because they could not get the support. The minimum wage will not cut it. The one thing we could do is invest in the one thing every health service needs - motivated staff. We are depleted in that regard at present.

Deputy Mick Barry: I have three questions. Before putting them, it has been interesting

to listen to the witnesses. I note the points that have been strongly made about elder care. My first question is about morale. I am picking up different threads from what has been said. Mr. Liam Doran mentioned the issue of low pay. Another issue mentioned by Mr. Eamonn Donnelly is the lack of buy-in when people do not know what is coming next. Restructuring fatigue and the staffing issue were also mentioned. Can the witnesses pull that together a little? The morale issue arises repeatedly among health service workers. Is it due to staffing levels, pay and confusion about the direction being taken? What is the balance between them and are there other factors? Perhaps the witnesses could put the jigsaw together in that regard with their knowledge and expertise.

My second point relates to a couple of interesting statements in the INMO document. This relates to an interesting issue that has not been raised here previously. The document states that integrated care requires a simplified organisational structure which clearly indicates responsibility for service delivery and that this can only be done by devolving responsibility, for the provision of all care, to the front line. It also refers to a fully integrated service, within a flat management structure, with responsibility, with autonomy, devolved to clinical front line managers who can access all services for the patient-client. The issue posed here is that of management and control in the day-to-day delivery of the health service. Some of the points in that submission remind me of what we use to see in documentation in the 1970s about workers' control of services and industry and so on, but leaving the ideological aspect of it to one side, in a practical pragmatic sense, can the witnesses give us a flavour of how they think devolving control and responsibility down to the grassroots, to those at the front line of the health service, would make it better? Could they give me some examples of that? I would be interested to hear their comments on that.

I heard the points that were made about a one-tier health service not being based on an ability to pay. The big question is how do we get from A to B. I listened to the points made about where the taxpayers' money goes and where it does not go and good points were made. I presume, but I would like it clarified, that the witnesses would support the idea of a health service which, effectively, would be free at the point of use, something like the NHS in Britain. That is not fully spelled out but it is strongly implicit in the document. I would like the witnesses to clarify that this is the position.

Chairman: I call Deputy Browne.

Deputy James Browne: I welcome the presentations by the witnesses. I have a few questions. On the issue of agency work and privatisation of health care in that sense, a considerable level of home care help has been handed out to agency workers. The HSE pays €33 or €34 per hour for this work but the staff providing that care often get barely over the minimum wage. There seems to be a serious level of inefficiency there and the public are not getting bang for their buck when we know the amount that is being paid by the HSE and the amount that the workers are being paid. Is that practice purely a reaction to meeting the demand for the service or is there an ideology in the HSE to drive on privatisation, with work in this area being an example of that? Tied into that is the issue of monitoring, we are seeing an increasing drive towards decongregation. Ms Patricia King mentioned that we are five or six years behind what is happening in the UK and I would be interested to read about mental health provision in the UK. In some cases, they have gone too far in terms of pushing people back into the community and we are seeing situations here where facilities are being run down in places like Kerry and so forth. The Health Information and Quality Authority monitors what happens in institutions, as does the Mental Health Commission, but there seems to be very little monitoring of what

happens in the community. Many agency staff are good workers but some people have told me that some of the people who have been hired to care for people in their homes are not qualified. I would like to hear the witnesses' comments on that.

Any change proposed by this committee would require buy-in from the trade unions and from the staff but even sometimes when that happens those in senior management leave it at that and think their job is done. To bring staff on board with change management and change implementation, how would the witnesses get the staff, who we know are fatigued as are management based on reports we have heard, to once again take another leap of faith and go along the change proposed? Other countries have a strong collaboration between staff and management and I would welcome the witnesses' comments on that.

We do not want this committee to simply produce another report that will gather dust. Do the witnesses believe that the report that will emerge from our deliberations should be underpinned with legislation? We are heading towards another period of instability in terms of future governments, with more coalitions. If it will take ten to 15 years to implement the report produced by this committee, we need not only a clear plan but to know that it will be implemented. Do the witnesses support the report that will be produced by this committee being underpinned by legislation? They would probably want to see what is in the report first but I would like their comments on that.

On a governance ethical model, do the witnesses consider that there should there be an annual assessment of staff and management in terms of capability or their ability to continue doing their job, or in terms of their professional development, as opposed to the current system where the competence of a member of staff or management tends to be only assessed when something goes wrong?

Chairman: We are ten minutes over time and other groups are waiting to come in. I ask everybody to be as brief as possible. I call Deputy Brassil.

Deputy John Brassil: I will be very brief. I have spoken to hospital managers and I am aware that they are paying way over the top for agency staff and are not allowed recruit staff. I do not understand the thinking there. What am I missing there if the cost to the HSE of taking on agency staff is three times the cost of recruiting staff and why would it not recruit staff? The witnesses might shed some light on that for me.

I was reading through the documentation last night and since the start of this process I have been trying to grapple with the structure around the seven hospital groups and the nine community health organisations. Is that a working structure? One line of the documentation I highlighted states that congress broadly welcomes the recent establishment of the seven hospital groups and it goes on to say that it is something that could work but reservations are expressed in some of the individual presentations, and Mr. Eamonn Donnelly also expressed reservations. I do not think there is an ideal scenario but should we set up a structure, go with it and modify it to fix it as we go along because we are not going to set up something right in the first place as it is too difficult a task? I would like hear the witnesses' opinions on that.

Chairman: I would like to add to that point. This is an issue with which we as a committee are grappling. We very much recognise the fact that there is change fatigue across the system and yet an issue that is raised here on a weekly basis is how do we have an integrated system when we have seven hospital groups and nine community health organisations, CHOs, and they are not aligned. There is not time to discuss that here. I do not know to what extent congress

has considered the organisational structures. I know Mr. Liam Doran said in his introductory statement that we needed a simplified, integrated and readily understood organisational structure. We certainly do not have that at the moment. Have the witnesses given much thought to organisational administrative structures, and, if not, they might come back to us on that point because it is an issue that has come up time and again. We are very slow to consider recommending yet another change but at the same time we cannot get our heads around the fact of how one could possibly have an integrated system with the level of disintegration between acute hospitals and community organisations.

Mr. Liam Doran: If we start from the back end, our population is only 4.75 million. The reason congress welcomes the hospital groups in the context of what was there before is that we have some level of cohesion and reduction in duplication. Prior to that, we had years where we had hospitals all competing for lung and liver transplants and so on. Therefore, the hospital groups is a step in terms of co-ordination and we will certainly come back on this issue. Let me be quite clear on this, there is no rhyme or reason to having seven hospital groups, nine CHOs, seven mental health areas and numerous section 39 facilities, all doing excellent work in their own way. We are not knocking the work but the management of that, as Mr. Eamon Donnelly said, leaves it impossible for people. On top of all that, we have a centralised HSE. To link that back to this being about devolving power, how does one run a health service where the local manager of a hospital is not empowered to fill posts that fall vacant within a hospital's stated staffing complement? They have to go up through three rungs of a ladder to live within pay and budget control and make a business case to people they never see who are up to 100 miles away.

I no longer want to hear the phrase "business case" in terms of running a health service. A manager of a local hospital or health service must make a business case to fill a post that has fallen vacant due to a person retiring, leaving or emigrating and wait six months for the position to be filled. That is why these posts fall on to the agency spend. What happens then is they cannot do it through the permanent pay structure yet they determine, as the lead clinician, that they need a staff member because otherwise patient care is compromised. The easy opt-out clause is to go to King and Doran Agency Limited and get the staff. A person could be in place for months, while waiting for the business case, at a cost of 5% on the shift premium and 21% VAT on the health service. That is how one ends up with an explosion in costs.

The other reason one ends up with an explosion of this practice is because the pay and conditions are unattractive, particularly with respect to our medical colleagues. They can choose to work via the agency model knowing that the hospital has to take them because they have no other way of filling the senior clinical decision-making gap. The medical agency spend has increased significantly in recent years because, in fairness to our medical union colleagues, they would say the pay and conditions are uncompetitive and so on. When we talk about devolving we are referring to those people who are responsible for the care. They must be empowered to maintain a staffing profile and be accountable for that expenditure. Everyone has to be accountable when spending taxpayers' money. At the moment, one has to be accountable but one has no autonomy to do it right and one is still accountable for the misadventures.

In terms of single tiered freedom, the health service is free at the point of use and no hidden charges have crept in. In terms of agency care, mental health and an increased drive towards congregated settings, the Deputy is right that it has become fashionable to talk about decongregated settings and forgetting totally about the needs of the person concerned, whether they have an intellectual or mental disability, to survive in a more normal community setting. Maybe he or she will blossom, be more productive and involved in the community if he or she has a more

protected environment. It is not that one goes from all residential to all community because there is that blend in the middle. The current Kerry situation is an example of that. No-one knows better than the relatives of the person as to how he or she blossoms. When the system dictates to the family what it thinks is right and the family's view is disregarded then we no longer have a public health service.

The final query was about hospital groups and rights. The only thing I would say, in deference to my colleagues, about what happens to the report is we would have a view that one has a right to a public health service. When one leaves it to discretion that is not enshrined. We had this with disability services. No-one wanted to pass legislation that gave a person a right to a service but one has the right to seek access to a health service.

In terms of a public health service, free at the point of use, universal and single tiered, yes if that can be brought forward and underpinned by legislation then I believe it would serve the community and the economy.

Ms Patricia King: We will take up the invitation to offer our view on some the supplementary matters that were raised in the questions that we did not get an opportunity to answer.

We welcome the opportunity to make a presentation. We also welcome the fact the committee has been set up. Issues were raised by various Deputies such as Deputies Kelly and Barry, but in terms of the most recent questions, if policymakers can grapple with and identify some of the big ticket issues, like the funding model and how the system works with fluidity, then one will start on the road to building the morale of the people who work on the ground. They will then see that the big ticket issues, that they know are unworkable and cause all of the dysfunctionality in the system, are from a policy point of view being taken on board and a group of policymakers trying to tackle them. That could be a game-changer in terms of how those who deliver the service at all levels react.

Mr. Paul Bell: I wish to respond to a question that a Deputy asked.

Chairman: Very briefly.

Mr. Paul Bell: Standards of care in the community or what was traditionally referred to as home helps has been mentioned. The only way of underpinning and addressing the issue for groups that were referred to as non-medical is for the service to be regulated. Those who provide the service should be introduced to a system of registration and meet specified obligations. The group would include health care assistant groups as well. In order for them to provide the service be it in a community or institutional setting one would require a certain level of qualifications. The service provider or individual must also be obliged to continually improve, train and be educated to meet that standard. The matter needs to be addressed.

Chairman: I thank everyone for coming here and being so generous with their time. I thank the witnesses for their submissions today and their original submissions. We would very much appreciate congress giving some thought to organisational structures. We are trying to grapple with this big issue and we would welcome an input.

Sitting suspended at 10.40 a.m. and resumed at 10.50 a.m.

Chairman: We will resume in public session. Is that agreed? Agreed. For the committee's second session we will discuss health service reform and the concerns of a number of organisations presenting to us. It is now the turn of the Irish Medical Organisation, IMO, to present

to the committee. I very warmly welcome, Dr. Peadar Gilligan, chair of the IMO's consultant committee, Dr Pádraig McGarry, chair of the IMO's general practice committee and Mr. Cian O'Dowd, policy and international affairs officer of the IMO. They are very welcome and apologies for the delay in getting started.

I advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

I invite Dr. Gilligan to make the first part of the opening statement.

Dr. Peadar Gilligan: I thank the Chairman and committee for affording the Irish Medical Organisation this opportunity to set out the views of doctors in Ireland on the future of Irish health care. As the committee is aware, the IMO is the representative body and trade union for the medical profession, representing all categories of doctors, including non-consultant hospital doctors, community health doctors, public health doctors, general practitioners and consultants. The experiences of the medical profession in Ireland have informed our submission to the committee. The development of a caring and effective health service is core to the mission of the IMO.

The written submission made by our organisation to the committee provides recommendations on a wide range of health service activities. However, I would like to focus the opening statement that Dr. McGarry and I are making on central aspects of the future of Irish health care, namely, capacity, staffing and the role of general practice. These are system-wide issues that, unless appropriately resolved, will inhibit development in other areas of the health service.

The media coverage of Irish health care frequently centres on hospital care, particularly emergency department overcrowding. As an emergency medicine consultant, I have been witness to the very real impact on patient care that cuts in health service funding have had. Our ability to provide high-quality care to patients in a timely manner is truly compromised in Ireland, as manifested by admitted patients spending in excess of 12 hours in emergency departments following a decision that admission is necessary and the increasing waiting lists for planned care delivery.

One of the most significant reductions made within the health service was to bed capacity. The effect of this is evident in every acute hospital in the country on a daily basis. There are in the region of 12,800 acute beds within the hospital system, 800 fewer than in 2007. Of these, 10,800 are inpatient beds, 1,300 fewer than in 2007. Contrast those 10,800 inpatient beds with the 14,700 inpatient beds which, in 2003, the Department of Health said we would need by 2011, or the approximately 14,600 inpatient beds we would have if we adopted the west European average. To put it bluntly, acute beds currently available within the acute hospital system are too few to provide care to patients in a safe manner. Unless urgent steps are taken to remedy this shortfall, many will continue to experience significant delays and preventable deaths will

continue to happen.

We have heard repeated promises of a bed capacity review but no action appears to have been taken. Such a review is needed to determine precisely how many and what types of beds should be placed within the acute hospital system to provide adequate capacity on a medium to long-term basis. In the short-term, however, inpatient beds must be restored to the system at a faster rate than is currently the case.

Deficits in medical staffing restrict patient access to care and the quality of that care. The 2003 report by the national task force on medical staffing - when applied to our current population - sets out a requirement for 4,400 consultants in the health service. Today, however, there are just over 2,700, and as a result we have long-waiting lists for outpatients and procedures across virtually all medical specialties.

Comprehensive manpower planning must be undertaken to develop a consultant-delivered health service. At present, however, we are being forced to cope with a grossly understaffed hospital system where the patient experience of care is not as their doctors would wish. Consultants and non-consultant hospital doctors, the next generation of consultants, are being pressed into excessive levels of service provision which jeopardises patient care through the generation of unacceptable clinical workloads. It is little wonder that few doctors see working in Ireland as an attractive choice or one compatible with their professional development. Accordingly, we have one of the lowest numbers of practising doctors *per capita* in the EU, at just 2.8 per 1,000 of population, compared to an EU average of 3.4.

As a direct result of a failure to honour consultant and trainee contracts, public sector cuts and the further catastrophic 30% reduction in salary to all new consultants imposed in 2012, there are in excess of 250 unfilled consultant posts in Ireland, with one quarter of advertised consultant posts receiving no applicants. This does not augur well for the future of hospital care in Ireland. Irish-trained doctors continue to leave the country in significant numbers. Figures gathered by the OECD reveal that Ireland has the highest reliance on foreign-trained doctors of any country in the EU. Our research has found that just 40% of Ireland's medical graduates plan to practise here, while studies by the Medical Council demonstrate that health service understaffing in Ireland is the leading reason why our doctors are leaving to practise abroad. Unless the issues of adequate acute hospital capacity and medical staffing are satisfactorily resolved, we will struggle to fill medical posts in our health service.

Inadequate resourcing of hospitals in Ireland has compromised patient care and, as a result, patients, and the staff caring for them, are suffering. There are also significant challenges for our colleagues in general practice, a subject which Dr. McGarry will now address.

Dr. Pádraig McGarry: I thank the Chairman for affording us the opportunity to speak to the committee today.

Despite its role at the heart of medical care and its presence in communities throughout Ireland, general practice is often neglected when it comes to health service planning. I work as a GP in Longford and, from first-hand experience, I can tell the committee that the under-resourcing of general practice in Ireland is one of the fundamental causes of its current inability to adequately meet patient demand. Population growth, shifts in population age distribution and increasing multi-morbidity in patients places greater pressures on general practice, while an ageing GP workforce and high-levels of GP emigration restrict the ability of general practice to cope with this increased workload.

In ten years' time, Ireland will likely have 60% more patients aged 65 years or older than is the case today - an increase of 20,000 in such patients every year for the next ten years. However, with 34% of GPs currently over 55 years of age and 17% of our newly qualified GPs working abroad, significant investment will be needed to meet future health care demands in general practice. The HSE has estimated that by 2025 an additional 1,380 GPs above projected levels may be required to maintain existing service provision, while an additional 2,055 may be required to provide universal care in general practice.

While attaining these increases in medical manpower may appear to be a daunting challenge, it is one that can be met. The solution can include: the agreement of a new fit-for-purpose contract for GPs that properly resources the work of doctors in communities; investment in evidence-based chronic disease management programmes; allowances for the employment of practice staff; supports that address the specific needs of practices and patients in rural and deprived areas; incentives for GPs to develop their practices; and swift access to diagnostic equipment for patients in general practice. All of this will result in the retention of newly-qualified and existing GPs, and a return of many who have left to practise overseas. This will create an environment where GPs want to work in the service.

I also want to briefly address some remarks that have been made in other meetings of the committee about the independent contractor model versus salaried GPs, and the role of other health professionals in general practice. On the first point, while there may be some merit in examining the role salaried GPs could play in some circumstances, the independent contractor model that currently exists in Ireland and most other developed health care systems broadly remains superior to other models in terms of its patient focus and value-for-money. GPs invest significantly in their practices and, once established, tend to remain rooted in their communities. This provides for a strong continuity of care experienced by patients and the lasting doctor-patient relationship, where a patient typically receives care from his or her specific GP, is associated with lower patient mortality and superior patient health outcomes.

This continuity of care may be threatened where GPs are salaried and, therefore, perhaps less rooted in their communities. The contractor model is to be distinguished from the corporate model, in which private firms invest in community health care for the purpose of extracting profit from the provision of services to patients. Such commercially-driven enterprises do not support the continuity of care in general practice that benefits patient welfare.

The role of other health professionals in the delivery of care is relevant to all categories of doctors. It must be borne in mind that different health professionals are educated and trained to perform different tasks. While there is scope for limited transfer in some areas of the health service, the shifting of significant aspects of doctors' work to the remit of other health professionals carries some negative consequences. In general practice, for example, non-physician health professionals often spend twice as long on consultations as GPs and use more health resources generally as a result of consultations. I point out this research only to demonstrate the reductions in efficiency and cost increases that occur when health professionals move into areas for which they are not trained and thus unsuited. All health professionals' education and training is highly specialised and tailored to the performance of specific tasks. We are not interchangeable. We must focus on ensuring the employment of sufficient numbers of health professionals of all types to guarantee the best patient outcomes.

As Dr. Gilligan already mentioned, our statement focuses on capacity, staffing and the role of general practice. This is not to diminish the other aspects of our submission. For example, proper provision must be put in place for long-term and rehabilitative care. On "Morning

Ireland" earlier, Professor Joseph Harbison highlighted this regarding rehabilitation beds for stroke patients. A new mental health strategy that puts mental health on a par with physical health and a detailed plan for its implementation must be put in place. A resourced and organised community health service and public health service must be provided, including expansion of public health capacity through a new fit for purpose contract. Appropriately developed capacity, staffing, and general practice are the foundations on which all other aspects of the health service are built, which is why we have placed so much importance on improving health care in these central areas.

I thank members for their attention. Dr. Gilligan, Mr. O'Dowd and I will be happy to address any questions they may wish to pose.

Chairman: I thank the witnesses. May we publish their opening statement?

Dr. Pádraig McGarry: Yes.

Chairman: I thank the witnesses. I now invite the members to ask questions in groups of three and we would appreciate it if the witnesses bank the questions.

Deputy Hildegarde Naughton: I thank the witnesses for their submission. In it, they make reference to staffing levels, which have decreased by 12.9% since 2007, and the number of acute hospital beds, which has fallen by 13%. Hospitals operate at an average of 92.6% capacity, which is well above the 85% capacity rate. Do the witnesses agree with hospital consultants on the need for more beds in acute hospitals? The usual response to such a suggestion is that medical science will obviate the need for more hospital beds and community care. I come from the viewpoint that, to date, no programme we have introduced has reduced the number of bed occupancy rates, and I would like to hear the views of the witnesses on this because it would form a very important part of our plan over the next ten years.

Deputy Alan Kelly: I thank the witnesses for coming before the committee. I am very much of the opinion we will have to move to salaried GP contracts. I read the opening statement and what the witnesses have said on this. There are a number of reasons for the move. We have gaps throughout the country. I have read what the witnesses stated on salaried GPs and independent contractors versus the corporate model. I am with them with regard to the corporate model so we can leave that aside. On the difference between salaried GPs and independent contractors - and I get the witnesses' point on investment in the community - will they indicate, in great detail, why they believe an independent contractor model would provide better value for money and why the services would be better than in a situation where GPs would be salaried. Do the witnesses accept that in some circumstances there will be a mixed model between salaried GPs and independent contractors because, simply put, in some parts of the country we will not have doctors otherwise? Do they think it is appropriate that we have salaried GPs throughout the country? How would we distinguish between how they would be paid and their facilities? Would there be certain conditioning based on the fact that some doctors would have to be put into rural areas where gaps exist?

The next issue relates to consultants, particularly those working in acute services in our hospitals. I am of the opinion that we will again be obliged to change our mode of action in this area and to directly employ consultants to work exclusively in the hospitals and exclusively for the public health service. We will have to grasp this nettle. We have issues in a range of specialties and I have no doubt - I accept the witnesses' point in this regard - that we do not have enough consultants in many disciplines. If, however, we are to have a ten-year plan for

the health service we will have to pay consultants adequately to fill these gaps. Taking this for granted, would it be best to phase in, over a period, salaried consultants who would be paid by the taxpayer and who would work exclusively in the public health service? We will need this to ensure that we have a single-tier health service, which is for what the committee is aiming.

There is a feeling among many members of the public, and certainly public representatives, that there is not just a two-tier system regarding the health service, there is also such a system with regard to how certain consultants operate *vis-à-vis* public and private patients. I have had much experience of that to which I refer to the point where I think that what is happening is, quite frankly, disgusting and unacceptable.

Deputy Pat Buckley: I thank the witnesses for their presentation. Deputy Kelly dealt with many issues and I will not rehearse what he said. The submission refers to the appointment of a national independent body to determine mental health catchment areas. This makes a great deal of sense because there are areas in the country with high rates of mental health issues and, unfortunately, suicide. Would such a body be neutral - that is, it would not come under the remit of HSE - and would it report on matters in a very frank manner? Would it work with coroners to get proper details on this issue? In the context of the many recommendations in the report, what arises time and again is the need to ring-fence funding. Funding is a major issue.

Dr. Peadar Gilligan: As to the first question from Deputy Naughton, absolutely staffing levels are a huge issue for us, and the loss of acute hospital capacity, specifically in-patient beds in the acute capacity, has been a huge issue. We certainly have seen a worsening of crowding situations and the further prolonging of waiting lists in the context of the loss of capacity. To me, if one were to think in terms of setting up a study to assess the impact of reducing capacity and staffing in the health service, we have done it and we know that it impacts directly on patient care. It creates delays in emergency departments for patients requiring hospital beds. It creates elongation of waiting lists.

With regard to Deputy Naughton's specific question, we absolutely agree that there is a requirement for an increase in acute hospital bed capacity. This needs to be informed by a bed review looking at our population demographic and the potential changes in this over the next ten years. We know that as we are currently we are not able to service the health care needs of our population who require hospitalisation in a timely and safe manner. We absolutely must address capacity. I thank the Deputy for the question.

With regard to Deputy Kelly's questions, I will leave the salaried GP component to Dr. McGarry if I may. On the issue of consultants and public-only salaries, this was addressed in the 2008 contract. Sadly, it is that group of consultants who work only in the public hospital system who have been most affected by the cuts under the public sector agreements and by the 30% cut that was imposed. We are now faced with a situation whereby more than 250 consultant posts have been left vacant. We have more resignations from consultant positions than ever before in the history of the State. This is largely because doctors feel they are not being adequately resourced in the delivery of services. They do not feel they that the necessary staff are being made available to them and surgeons are of the view that they do not have the necessary time in theatre. While it was identified within the 2008 contract that there was a role for an entire commitment to the public system, that part has suffered most as a result of public sector cuts. We must also be cognisant of the fact that there is a 2008 contract for consultants that has never been honoured by the employer. That has had a dramatic impact on recruitment and retention. A 30% pay cut to all new consultants had the most devastating effect on our ability to recruit and retain because suddenly we were saying to doctors we wanted them to take on all the re-

sponsibilities of being consultants, and they are considerable, to delineate them in the form of a contract but we would not honour that contract when it came to the terms and conditions they could expect, and all new entrants would be paid 30% less. It makes no sense at all and until it is addressed and fully reversed, we will not be able to recruit and retain consultants within the Irish health system to provide the level of care that we know we can and want to provide.

In response to the question on the requirement for independence of a commission examining our mental health services, it is very important to have that independence because there are so many things that need to be examined and there is a significant requirement for the resources in that area. Suicide is a huge problem for our population and has devastating consequences for the families and friends of the individuals who commit suicide. We need to be in a position to prevent that to the greatest extent possible. Our current system is under-resourced to allow that happen.

Dr. Pádraig McGarry: I will answer the second part of Deputy Kelly's question first. There needs to be a mixed model because there certainly will not be a one-size-fits-all formula-----

Deputy Alan Kelly: Three parts or two parts?

Dr. Pádraig McGarry: We need different models for it. In isolated areas such as the islands, in certain rural areas and areas where it is difficult to attract doctors, a salary model would work, but the independent contractor model has been shown to work much better in all developed health care systems throughout the developed world. Putting a salaried general practitioner in the midst of a mixed model possibly undermines the whole structure. If there is a salaried GP whose costs are all taken up by the State and the cost base is very different from that of the surrounding GPs, it undermines the viability of those GPs on the ring. That ring would have to extend further. If it could be done in one fell swoop, it possibly would work, but if it starts in isolation it has a ripple effect which could undermine existing practices. There could be unforeseen consequences.

Deputy Alan Kelly: Dr. McGarry admits that there are areas where we will probably have to put in salaried GPs.

Dr. Pádraig McGarry: Yes.

Deputy Alan Kelly: How does he define the ripple?

Dr. Pádraig McGarry: Salaried GPs can be put in but that could very well cause problems. If one is put into a particular area-----

Deputy Alan Kelly: I know what Dr. McGarry is saying but I do not accept it. Somebody will have to bite this bullet and say these are the conditions where it has to be put in or it may not be put in.

Dr. Pádraig McGarry: I am not saying we do not necessarily have to have them but there are unforeseen circumstances and repercussions which may undermine existing practices.

Deputy Alan Kelly: It sounds like Dr. McGarry is hedging his bets.

Dr. Pádraig McGarry: I am not really. It is a realistic approach.

Deputy Alan Kelly: It is not because Dr. McGarry is not defining it. Could he define it, please?

Dr. Pádraig McGarry: Let us say we put a salaried GP in an area where there are five GPs, four of whom are independent contractors. They have a totally different cost base.

Deputy Alan Kelly: I understand that.

Dr. Pádraig McGarry: They are functioning general practices.

Deputy Alan Kelly: What happens if the person is in rural Clare?

Dr. Pádraig McGarry: I have accepted there is a need in certain areas but it will have consequences as well.

Chairman: Is the issue not premises rather than whether GPs are salaried or contractors?

Dr. Pádraig McGarry: It is more than premises. It is staffing, information technology, IT, and the whole cost base of a general practice. Premises are not necessarily-----

Chairman: I presume the cost of staffing should be recognised in the contract or provided by the State. It strikes me that while Dr. McGarry has a genuine concern about GPs who have already invested in their premises, whether a converted house or a primary care centre------

Dr. Pádraig McGarry: It is more than the premises though.

Chairman: -----the concern is about undermining that. Would it not make more sense for us to recognise the issue of premises? Dr. McGarry says GPs invest significantly in their practices. That is fine for GPs who can do that but there are many who are not in a position to invest in practices. They are doctors first and foremost rather than business people. It is a matter of recognising that cost in a new contract or a salary.

Dr. Pádraig McGarry: I agree, and that is probably one of the obstacles that newly emerging GPs face because there is a huge capital outlay at a time when they are in the most precarious situation. A new contract should recognise that by giving costings to help them establish that. I absolutely agree with that.

Chairman: I often make the point that we would not expect teachers to provide their own schools-----

Dr. Pádraig McGarry: That is right.

Chairman: -----so we should not expect doctors to provide their own primary care centres. For those who have, that needs to be recognised.

Dr. Pádraig McGarry: It has to be recognised for those who already have it but it can possibly undermine existing situations as well. This is not just a question of the premises. It relates to their functioning and viability.

Chairman: That is not necessarily an argument against going with the new system but is something that needs to be recognised.

Dr. Pádraig McGarry: Yes.

Deputy Michael Harty: I am an ordinary member of the Irish Medical Organisation. Over recent weeks we have been discussing a change of work practice because if we are to change our health service, we must change the health model. I would like the witnesses' views on

changing work practices. The work practices for GPs and hospital medicine have been in place for 40 years and the health service has moved on but the practices remain the same. There is huge room for changing work practices, and that feeds into integration between primary and secondary care where there is a big gap. Should that integration be from the top down or the bottom up? We have heard the Carlow-Kilkenny services talk about how they integrated care and the efficiencies that has brought about.

Recruiting GPs to single-handed practices, urban or rural, will be very difficult in the future and we will have to change the model. In rural areas it may be a salaried position but in urban areas it will have to be the primary care centre model. The witnesses might comment on those points.

Deputy Louise O'Reilly: I thank the witnesses for their attendance here this morning and their presentation. There is a great deal of talk about primary care and the need to shift in that direction. We heard evidence from colleagues of the witnesses that it is possible to manage 95% of chronic conditions in the community with the requisite supports and resources in place. That would reduce the reliance on the acute hospital sector. What would the witnesses' vision of a fully staffed functioning primary care service look like? What would the employment relationship be between an independent contractor and all of the other staff that are necessary? I understand that as an independent contractor, a GP would employ a practice nurse. It is easy with a salaried GP because everybody works for the same employer but in a fully staffed proper primary care centre, how do the witnesses envisage the relationship between the Health Service Executive and the primary care centre? How would it work with an independent contractor?

My second question is on skill mix. For my sins, long before I was here, I was a member of the European working time directive implementation group. We talked at length about skill mix. Every single group in the room said they wanted to do more and they wanted do things differently. There is clearly a blockage because that committee sat and met for a long time and we could not get over the skill mix issue. I am interested in the witnesses' views about where that blockage is, because there clearly is one, and how we might get around it and better manage and utilise the skills we have in the health service at the moment.

Chairman: I thank the Deputy. Does anyone else want to ask a question?

Deputy James Browne: What are the witnesses' views on cross-referrals where public health nurses could be allowed to prescribe in certain situations or allowed to open up referrals to paramedics, OTs, or psychologists and other necessities beyond GPs?

Chairman: I thank Deputy Browne. I will bring Deputy Kelleher in as well.

Deputy Billy Kelleher: I apologise for missing the presentations but I was listening as they were being broadcast. There are a number of issues. We talk about primary care and primary care teams. How much will GPs embrace working together? Are they reluctant? Let us be very clear, there was resistance by a lot of GPs to the initial move to roll out primary care teams across the country. It was one of the factors that delayed the process. In terms of working together in the primary care setting with a primary care team, is there still resistance from GPs to embracing that broader concept? If there is, we have a huge difficulty because it will be the backbone of how we deliver primary care in the years ahead.

One challenge is retaining GPs in some areas, particularly those where there are lower socioeconomic groupings or financial deprivation, and in rural areas. What are the witnesses'

views on the issue of salaried GPs in view of the fact we are at times unable to recruit or retain them?

Chairman: We dealt with that issue at some length.

Deputy Billy Kelleher: I do not know if the question was answered in detail so perhaps it could be revisited.

Deputy Mick Barry: It was questioned in detail.

Deputy Billy Kelleher: Yes, but answers would be helpful. The issue of consultants has been addressed before. What comparable pay rate should we be looking at if the issue of remunerative packages is a problem in recruiting consultants? We compete in the English-speaking world as opposed to the European model in terms of retaining or attracting back consultants. What sort of pay rates do the witnesses recommend should be looked at to attract the number of consultants we require?

Chairman: Will the witnesses address those questions?

Dr. Pádraig McGarry: There are a lot of questions so I will try to answer the ones that stick in my mind. Primary care teams are a very effective way to deal with patients' problems. The focus to date has been on primary care centres. A primary care team involves the interaction between various health professionals but it does not have to be within the one building. It is something that has been going on for years. We interact with public health nurses and physiotherapists on a daily basis so the concept of interacting and working with primary care teams is nothing new. It is perhaps more formalised in some way but it has been working very well for a long time. Primary care meetings means perhaps setting aside two hours to go through the cases of individual patients. In many cases it was felt that not an awful lot of productivity came out of it. It was more of a box-ticking exercise than actually caring for the patient. If I need to deal with a particular patient, I will liaise with the public health nurse, the physiotherapist or the OT and sort it out. It is usually done through a phone call. We do not have to be in the same room to do that nor do we have to be in the same building. I do not think there is a reluctance to deal with primary care teams. It has been going on for years and I do not see why that would change.

Deputy Billy Kelleher: Is it about a reluctance to have primary care centres as opposed to a reluctance to have primary care teams?

Dr. Pádraig McGarry: It is an issue of one having to be in a particular area for two hours. Two hours in a GP's day is an enormous amount of time. We are snowed under with work. To give a two-hour time allocation for what may turn out to be two patients is an enormous time resource which we can ill afford. If we can deal with the issues on a much more efficient, one-to-one basis, which is how it has been done in the past, it should be looked at more and should continue. I have no issue with dealing with primary care teams in that respect.

Chairman: A number of questions were asked about the skill mix.

Mr. Cian O'Dowd: I will say a few words about the skill mix. One of the leading reasons NCHDs, in particular, are leaving this country is because they feel they are carrying out too many non-core tasks. That is listed as the third highest reason, after under-staffing and career progression issues. There is a need for task transfer in certain areas and there is provision in the MacCraith report for that. My understanding so far is that it is not really known the extent

to which the transfer of tasks has actually occurred. I accept the point there is scope for it to be looked at. As Dr. McGarry suggested, there is a need for allied health care professionals within the primary care system but they have to be there in sufficient number. Resources have to be provided in order for a GP to adequately refer to them. It is only in that context that there can be a properly operating primary care system.

Chairman: In the presentation and just now, Mr. O'Dowd referred to some research. That is Medical Council research on the reasons consultants are leaving.

Mr. Cian O'Dowd: Yes, that is right.

Chairman: Will Mr. O'Dowd take us through the first few reasons? The top one is under-staffing.

Mr. Cian O'Dowd: The top one is under-staffing. If we look at the Hanly report in 2003, it shows that if we were to have a consultant-delivered health service in this country, based on our current population and the ratio set out in that report, we would need approximately 4,400 consultants. Currently, we have 2,700.

Chairman: It was the list I was looking for. What is the second reason?

Mr. Cian O'Dowd: The second reason is they are expected to carry out too many non-core tasks. They feel there are limited career progression opportunities. There are pay issues both with regard to earning capacity and getting paid for overtime and getting paid regularly. The fifth one is not having flexible training options.

Deputy Alan Kelly: Are they prioritised in order?

Mr. Cian O'Dowd: They are prioritised in order.

Deputy Alan Kelly: Pay is the fourth reason.

Mr. Cian O'Dowd: Pay is the fourth reason. These reasons are given by respondents who said they were either definitely or probably going to leave. The percentage of respondents that agreed with those statements is very similar. The top reason had 82% agreement and the fifth reason had 70% agreement. There is a large number - one in five doctors - who feel they will either definitely leave or will probably leave. The vast majority of them feel these are all relevant issues that are playing a part in their decision to consider leaving or to definitely leave.

Chairman: On the question of career progression, how does Mr. O'Dowd propose that be dealt with? There was talk at one stage of introducing a middle-tier specialist position. It seems to be all or nothing now when it comes to medical consultants.

Mr. Cian O'Dowd: We have backed the idea of a consultant-delivered health service and the evidence is there to suggest that consultant doctors, when delivering care on the front line, do so faster, more efficiently and in a more cost-effective manner. There should be enough consultant posts within the system in a consultant-delivered health service to adequately address career progression issues within the NCHD cohort. It requires an undertaking to say that we are committed to the idea of a consultant-delivered health service and are going to put it in place in the interests of patient welfare. I do not know if Dr. McGarry has any thoughts on that.

Dr. Peadar Gilligan: If I might, I might answer on a few of the issues. It is very appropriate that the committee's emphasis is on primary care and general practice because that is where

the vast majority of health care interactions happen in this country on a daily basis. The issue of salaried GPs has been raised a number of times. It strikes me that we might not quite realise the asset we have in the current model of general practice. The independent practitioner is strategically responsible for his or her practice, manages his or her practice with the help of his or her practice manager, provides services, and knows his or her patients incredibly well. Because GPs know their patients extremely well, they tend to have quite low referral rates to the hospital system. Before we move away from a model that provides a terrific level of care, we must be conscious of the value that is already there.

Deputy Harty suggested there had not been a change in work practices in hospital medicine in Ireland in 40 years. While I have not been in hospital practice for quite 40 years, albeit there are days when I feel it has been 80, I assure the Deputy that it has changed hugely. To give one example, a patient with stroke coming to hospital ten years ago was managed largely in a palliative manner. Now, within three and a half hours of onset of symptoms, we are in a position to potentially thrombolise and reverse the effects of that stroke. Heart attack management has hugely changed. Historically, it was aspirin and oxygen, but we now treat that patient with a ST-elevation myocardial infarction to the cath lab within 90 minutes of arrival at hospital. We decrease the amount of heart tissue lost as a result of the heart attack. Those are just two examples across many, many specialties. As such, there has been absolute change in the hospital system and in the way we deliver care based on the evidence and what is best for patient care. The frustration for us as hospital doctors is that we know what we can do, but do not have the resources in place to do it. We do not have the staffing or capacity in place and sometimes we do not actually have the equipment we need to provide the care.

There was a specific question around the Carlow-Kilkenny model. In essence, the acute medical admission model and an interface with primary care and general practice has a role, but the Carlow-Kilkenny situation is really quite different. In the hospital where I work, if we had the number of nursing home beds available to us as per the demographic of our population that Kilkenny has, we would not have the problem we do with overcrowding. At any given time, 20% of our bed base is occupied by patients who would be better cared for, having undergone and completed their acute care, in a nursing home setting. However, we do not have those available to us. As such, it is not a model that can be rolled out across the country. The other thing to be cognisant of with regard to acute medical admission units is that unless they represent a real increase in capacity within the hospital and unless they represent an increase in staffing in the hospital to address the needs of the acutely admitted patient, they tend not to work. That can be seen nationally where acute medical units are failing because they do not have the resources they need. They do not have the bed base and do not have the ability to move the patient through the acute medical admission unit onto the ward because there is no ward available.

I was asked by Deputy Browne about allied health professionals and prescribing. There is a doctor's role and doctors perform it extremely well. There are also incredibly important roles in nursing, occupational therapy, physiotherapy and the social work departments of our hospitals and it is incredibly important that we identify the importance of those roles and support the people in them. We do not want and we do not need everyone doing the doctor's job. In fact, some of the time, what we need is for doctors not to have to do jobs which are not appropriate to that role so that they can get on and do the doctoring role. That is a model we need to look at but as things stand, we have prescribing rights for groups who go through a particular programme. For example, we have advanced nurse practitioners with prescribing rights throughout the country.

On the retention of consultants and the pay rate Deputy Kelleher mentioned, the last time we had a negotiated contract in Ireland was 2008. At that time, a pay structure was put in place, but it has never been honoured as I have identified for the committee. We have a real problem with regard to that. Not only has it not been honoured, it has been serially cut and then, dramatically, a further 30% cut was superimposed on the earlier cuts. We have a situation where hospital doctors do not actually feel their contract will be honoured by the employer side and that must be addressed. The Deputy is absolute right. The current pay rate and the concept that someone takes on a consultant role and does the same job as the person beside him or her but gets paid significantly less because of the time of his or her appointment is a huge barrier to recruitment and retention in the system currently.

Chairman: A number of members asked about the skill mix in primary care. I was surprised to hear in the presentation that there was scope for limited task transfer because a lot of witnesses coming to us have talked about the need for task transfer. We are talking about the need to concentrate on chronic disease management and a great deal of that work would be nurse-led. As such, I am surprised to hear that statement.

Dr. Pádraig McGarry: There is scope for it.

Chairman: A number of members have asked about that.

Dr. Pádraig McGarry: I was going to address that in relation to Deputy O'Reilly's question on chronic disease management. She rightly said that 95% of chronic disease management could and should take place in general practice. There are models out there which have been in existence for the last ten or 12 years, notably Heartwatch and the diabetic midland care model, of which I am part myself. Under those models, the vast majority of cardiac and diabetic patients are monitored on an ongoing basis through preventative care in general practice. A lot of that work is carried out by the practice nurse overseen by general practitioners. Certainly, there is a role. The chronic disease management roll-out needs to be expanded beyond just the diabetes model. The Heartwatch model has been shown to be hugely beneficial for patients by reducing risk factors by up to 50%. That has to be expanded into a multi-morbidity model because there is movement away from single-disease models. We need to look at a multi-morbidity model because the likelihood is that a diabetic patient also has some heart disease and other issues. Rather than to have a single focus, the care model needs to be broadened out. We have actually been doing work on that. We have surveyed our practices to see what workload is involved and we have worked with Professor Brendan McElroy who has experience of the Scottish system's development of such a model. There will be room in that respect for task transfer.

Chairman: I thank Dr. McGarry for that clarification.

Deputy John Brassil: Going back to the GP issue, I agree that the independent contract model has worked very well. The problem we have, however, is that there are increasing numbers of areas where GPs are retiring and there is no prospect of getting a replacement. I dealt with a situation in my home town of Ballyheigue a number of years ago where a GP emigrated and we had an extensive battle to get somebody to take on a very attractive GP practice. On the Iveragh Peninsula in the Caherciveen-Waterville area, there were seven GPs a decade ago. At Christmas this year, the GP in Waterville will retire because he is 72 and there will then be two GPs. I have made requests and tabled parliamentary questions repeatedly and have received the standard reply that the practices are being advertised. There is a real problem. The new contract may solve it but I suspect there is a need for a HSE-led type of contract to facilitate places where an independent contractor just will not go. I compliment the Irish Medical Organisation,

IMO, on its presentation and 14 recommendations. It is welcome to see the solution coming from those working in the area. However, if we need 2,000 extra GPs, the current model, good and all as it may be where it works, will not suffice. Every time the committee refers to GP's salary or some iteration of it, we do not get any buy-in.

Dr. Pádraig McGarry: I agree there needs to be a model and it cannot be a single-fit fits all. In the specific areas described by Deputy John Brassil, the need for a salaried general practitioner needs to be recognised. What I am referring to with the individual model is more across the board rather than in isolated problems. There is significant scope for that type of arrangement and a contract will have to reflect that.

What will have to be taken into account is the significant cost to the State or whoever will be the paymaster for that type of arrangement. If one takes on a salaried general practitioner, one will have to take on all that goes with it such as premises, employment of staff and IT. It is not just a question of employing a salaried GP. It will be necessary to employ other staff to go with that. That could prove expensive if it was rolled out across the country.

I agree with the Deputy on the individual cases referred to where there is a particular problem. Due cognisance has to be taken, however, as to what that is likely to cost the Exchequer and if it is affordable. That is for the committee to determine.

Deputy John Brassil: The committee has heard already from other medical personnel, the Irish College of General Practitioners, ICGP, and the Irish Hospital Consultants Association, IHCA. The IMO is the only body which represents all doctors. Is there a good healthy relationship between it and the other representative bodies?

Dr. Pádraig McGarry: We have always had a good relationship with the ICGP. A joint committee has been established to look at standards and how we need to progress chronic disease management. There has always been a good relationship in that regard.

Chairman: At our meeting last week with Professor Tom Keane, he spoke about the importance of clinical governance and how he believed it should take place at local hospital level rather than with the Medical Council. What is the IMO's view on that?

Dr. Peadar Gilligan: We would concur with that. Nationally, the reality is that most governance issues are dealt with in the local hospital. The hospital group model is in development and it would be rare to need to escalate a local governance issue to the hospital group.

Chairman: There is clinical governance and then there is performance management. Specifically, in situations where there is an adverse incident, rather than it being dealt with by the Medical Council, Professor Tom Keane expressed a strong view that it should be dealt with in annual reviews of performance at hospital level.

Dr. Peadar Gilligan: Generally, what happens in that context at a local hospital level is that most hospitals will have morbidity and mortality meetings, as well as meetings to address where there has been an adverse, or perceived adverse, incident. Nearly all hospitals will have a patient representative office. If there are incidents, or perceived incidents, they will be brought to the attention of the clinical team, oftentimes through that office. An internal report will be developed and, if necessary, the patient and-or family will be met with to discuss the issues arising.

There is much of that work ongoing within the hospital system. I agree with Professor Tom

Keane that there are cases coming before the Medical Council which should not be and could be better dealt with locally, both from patients' perspective and the health care side.

Chairman: Does the IMO agree with Professor Tom Keane that this needs to be underpinned by legislation?

Dr. Peadar Gilligan: Yes, I think so. Then again, the hospital group model needs to be underpinned by legislation.

Chairman: Finally, a question I have already put to most of our witnesses relates to the organisational structures in the HSE. If we are aiming for an integrated health service, does the IMO believe the structures in place, with seven hospital groups and nine CHOs, community healthcare organisations, which are not aligned, militate against the kind of integration we need?

Dr. Peadar Gilligan: It certainly creates a significant challenge, which is the short answer to that.

Chairman: That is very diplomatic.

With that, I thank the IMO for its attendance and comprehensively dealing with the committee's questions.

Sitting suspended at 11.47 a.m. and resumed at 11.49 a.m.

Chairman: I welcome from the Irish Nurses and Midwives Organisation, INMO, Ms Martina Harkin-Kelly, president, Mr. Dave Hughes, deputy general secretary; and Mr. Edward Mathews, director of regulation and social policy.

I advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. If they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter only to a qualified privilege in respect of their evidence. Witnesses are directed that only evidence connected with the subject matter of these proceedings is to be given and are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing ruling of the Chair to the effect that members should not comment on, criticise or make charges against a person outside the House, or an official by name or in such a way as to make him or her identifiable.

I invite Ms Martina Harkin-Kelly to make her opening statement.

Ms Martina Harkin-Kelly: I thank the Chairman. On behalf of the Irish Nurses and Midwives Organisation, INMO, and the 40,000 members we represent, I wish to begin by thanking the committee for affording us this opportunity to meet and engage with them on the hugely important work of this committee and the potential it offers - supported by the political system - to reform our inequitable health system. The INMO wishes to state that the work of this committee must be the first step in a radical, comprehensive, transformational and sustained process of change. This must lead to a seamless, universal, single-tier health service, with access based solely on health need rather than ability to pay. In putting forward this view we accept that moving from our current inequitable two-tier system will require, at a minimum, up to 15 years.

This change will also require political consensus stretching far beyond the normal electoral cycle and will necessitate future Governments and Opposition parties accepting the process of change complete with the funding and resource requirements necessary to deliver that change.

The INMO also supports the view that a single-tier service it must be funded to the tune of a minimum of 10% of gross domestic product, GDP and 12% to 14% during the transitional period. In addition we must have a separate funding system and stream, spanning five to seven years, providing for the necessary capital investment to improve existing health infrastructure and develop new community based health facilities. In delivering a quality-assured, accountable and responsive service, it will also be necessary that we have a simplified and lean organisational structure. Funding and real accountability must be devolved to front-line managers - primarily nurses, midwives and health professional managers - who can respond to changing demands, needs and demographics in a much more flexible way than is possible in the context of the current bureaucratic and layered management structure.

I will now turn to the current realities. Our written submission has detailed the very bleak journey Ireland's public health service has endured in recent years. More than €4 billion has been cut from health funding, which is an unprecedented contraction of expenditure in any OECD country. There has been a loss of over 2,000 beds. Public supports for vulnerable people have been undermined such as the privatisation of services for older persons services, the curtailment of mental health services curtailed, the silent but hugely damaging cuts in disability services and the very severe contraction, despite commitments to primary care, to public health and community nursing, home care, home help and related services.

The injurious, unmanaged and unmeasured contraction in staffing levels has resulted in a loss of more than 5,000 nursing and midwifery posts, 13.5% of the workforce. The system is still working with some 4,000 less nurses and midwives than it had in 2009, compromising patient care on a daily basis. We have a loss of 3,500 general support and care staff and a reduction of 1,200 in the number of clerical and administrative staff. It is acknowledged that during this period there were some increases, including in respect of the number of medical personnel by more than 1,500. There was also a small increase of 800 in the number of allied health professionals. The impact of this unmanaged contraction, driven solely by budget considerations regardless of its outcome upon patient care or the ability of the health service to meet demand, has been completely underestimated by the political system and this is evident in record levels of admitted patients on trolleys in overcrowded emergency departments and wards. Record numbers of patients are on hospital waiting lists and waiting lists for services in the community.

This committee must be acutely aware that this contraction resulted in the forced emigration of young, recently-graduated health professionals in the nursing, midwifery and other allied health fields. In considering any real transformation for our health service the first challenge will be to attract back these health professionals while we also educate additional numbers and ensure they remain in Ireland upon qualification. The committee must recognise that the morale among nursing and midwifery staff has never been lower. They feel totally disrespected by their employer and their professional judgement is, on a daily basis, set aside or ignored by senior management whose continuing focus is solely on budgets and numbers and not on the needs of patients and service users. It is against this reality that the required transformation must begin with the replacement of lost staff, together with the recruitment of additional staff, which will require sustained investment. If we do not have nurses and midwives, and other front-line staff, we do not have a health service that is fit-for-purpose.

Consider the transformation and what is required. In calling for this major organisational

transformational programme the INMO recognises that it must be in tandem with how and who delivers care, and where that care or support is provided in the context of devolved funding and accountability arrangements. The fundamental principle of our new and changed health system must be a guarantee to any service user that they will receive integrated care whether they need it in the home, in a primary care setting, an acute hospital or a long-term care environment. There can be no silos with regard to budgets or who delivers care. Such silos are currently real and growing barriers to meeting the needs of patients and service users.

It is against this background that the INMO makes the following points to the committee on organisational reform. In the context of 11 years of organisational reform, with no improvement, the INMO, as part of this transitional programme, believes that certain measures must be put in place including: simplified organisational structures from the Department of Health; regional health authorities; and individual local units and areas. There is no cohesion or accountability within current structures, which include the Department of Health, the centralised HSE, seven hospital groups, nine community health organisations, 17 mental health areas and numerous section 38 and section 39 service providers. This lack of cohesion will always result in a lack of transparency and accountability with front-line staff not having the necessary autonomy, with responsibility to shape service delivery to meet patient or client need.

In the context of transforming models of care, this overhaul must result in nursing and midwifery and medical staff being empowered, with accountability to deliver care at the most effective level. The INMO would put forward the following framework in this regard. The single-tier service would see all new appointments to consultant and general practitioner posts involve a public-only contract including an obligation to work rosters on a five as opposed to a seven-day basis. Existing consultant and general practitioner post-holders who do not wish to change their contracts must be allowed to retain them. All new appointments should be replaced with public only contracts. This will require an increase in the number of consultants to our public health service. This can be partly funded by a reduction in the number of non-consultant hospital doctor, NCHD, posts, reducing our current over-reliance on medical staff undergoing continuing training or education in the clinical area. There should be very significant expansion of the role of the nurse and midwife in all clinical areas requiring a significant increase in the number of nurses and midwives in the hospital and community who are empowered to prescribe within agreed protocols. There should also be an expansion of nurse and midwife led services involving advanced nurse and midwife practitioners as follows: the empowerment of nurses and midwives to order diagnostic tests such as X-rays and bloods, whether they work in hospitals or community settings; the mainstreaming of an expanded role with regard to first dose antibiotics; intravenous cannulation for fluid balance; out-of-hours phlebotomy; nurse-led discharge; and other appropriate roles within all care settings. The role of the health care assistant, including their job descriptions and training pathways, must be standardised, nationalised and become the minimum required for entry to this grade. This is an essential part of front-line reform which should lead to best practice skill mix ratios such as 80:20 for registered nurses and health care assistants in acute medical and surgical wards and 50:50 for registered nurses and health care assistants in care of the elderly facilities, as confirmed by international research by RN4CAST.

I will now turn to devolved funding. The INMO is also calling for reform leading to a practice where funding is devolved to units, wards and community level. Currently, front-line managers have no input into what funding is required and can work the whole year without ever knowing what funding was given to their area or unit, which leaves them in an impossible position. In simplifying organisational structures, the INMO is also calling for new accountability

rules which would ensure the director of nursing or midwifery is involved, at all stages, in the formulation of the annual budget for that location and area. Once the budget has been finalised for that area or location, it would then be devolved to the front-line manager, that is, the clinical nurse manager or the head of physiotherapy, who assumes responsibility and accountability for the budget but with complete autonomy as to what services can be delivered safely within that budget. Directors of nursing and midwifery and senior hospital area managers, as appropriate, would be empowered to seek amended funding levels to reflect changes in service demand, acuity and dependency.

The greatest damage done to the health service in recent years has been the totally unmanaged contraction of staff numbers. This, in turn, is a major reason for the broken spirit and morale of front-line staff, particularly nurses and midwives, at this time. As we embark on this transformational programme we must introduce an evidence-based approach to staffing our health service at levels which optimise the well-being of patients.

This process is already under way through the work of the task force on nurse staffing and skill mix in adult medical and surgical wards. The further roll-out of this approach to staffing is fundamental to the transformational programme and the next area planned is emergency department nurse staffing. This work must be accelerated, and we use evidence-based mechanisms, as determined by the front-line manager, that is, the CNM2, to determine appropriate staffing and skill mix requirements.

It is self-evident, and very regrettable, that to date the HSE, the Department of Health or the Government have not done enough to address the loss of our best and brightest young professionals. Therefore, the public service pay commission must be accelerated and FEMPI unwound, together with the early renegotiation of the Lansdowne Road agreement, in order to garner trust within staff to deliver this radical transformation. In addition, it is the belief of the INMO that the crisis with regard to nursing and midwifery recruitment and retention requires unique measures to be brought forward immediately to reduce current excessive workloads and improve patient care. No matter what model of health care is used, the reality is that all health systems are labour intensive and must be staffed by committed, dedicated and flexible people. This must be recognised with the health service being an employer of choice offering excellent pay and conditions.

As we state in our written submission, the latest OECD figures confirm that in 2013 the Government's allocation to public health spending was 72% of GDP. The OECD figures also indicate that when this public expenditure is combined with private health expenditure the overall health spend in this country is approximately 10% of GDP. However, the manner and nature of this expenditure, which clearly reinforces the two-tiered structure, only serves to guarantee faster access to diagnostics and treatment for those who can afford private insurance or direct out-of-pocket expenses. This is inherently unfair and inequitable.

Therefore, in calling for a public health spend of no less than 10% of GDP, and 12% to 14% during transitional years, we recognise that this must be done with total transparency so that it secures and maintains the confidence of all citizens and taxpayers. We also call for the phased abolition of all tax reliefs pertaining to private health insurance, the ending of any contracting for services to provide direct care and the phased ending of subventions to private nursing homes, while recognising this will take an extended period due to existing contracts and bed stocks and the need to develop new publicly-funded direct facilities.

In recognising the challenge that meeting future health costs will bring, we draw the atten-

tion of the committee to recent papers produced by the Nevin Economic Research Institute, which remind us that by 2046 the number of persons over 65 years of age will have increased from 606,000 to 1.8 million. In addition, we face the growing epidemics of obesity and alcohol abuse which will also increase demand on our health service. Against this stark reality, the political system must fully understand the implications of these demographic and lifestyle changes. All taxpayers must also understand that we cannot reduce general taxation levels and provide the same type and extent of health service the population will need.

Our call today to the committee is to begin the revolution necessary to deliver a single tiered health system within 15 years, which will serve all the people of this country equally and in a world-class manner. In calling for this, we also recognise that health service structures and how all health service staff work must also be subject to transformation. No vested interest should be allowed to halt the pace of progress necessary to prepare for the growing demand that will be made on our health system.

To deliver this change will require the health service, including its funding and structures, to be removed completely from the traditional electoral cycle and budgetary practices. We ask members to make these recommendations, safe in the knowledge that all future generations of Irish citizens will live in a more equal society with regard to health care, which is an investment in the future and will realise healthier communities and a stronger economy.

Chairman: I thank Ms Harkin-Kelly for her very comprehensive opening statement. It dealt with many different areas. I will now invite members to speak in groups of three. I ask the witnesses to record the questions and then respond.

Deputy Louise O'Reilly: I thank Ms Harkin-Kelly for her presentation. It is fairly comprehensive.

The question of the skill mix has arisen a number of times today, and there is general acceptance that we could do better. There is clearly a blockage, because people have been talking about this issue for a very long time. Various groups have a view on where the blockage might be. Given that we have to tackle the issue, I ask Ms Harkin-Kelly to outline her views on where the blockages are and what could be done to improve the level of skill mix within the health service in the short and long term. It is not something that can be fixed overnight.

Ms Harkin-Kelly referred to the broken spirit of nurses and midwives, and the general population of health service workers. What can we do about that? The purpose of the committee is to devise a plan, but a plan is completely useless unless we can get buy-in. How can we establish credibility among health care professionals?

We discussed the public-private ratio. I would be interested to hear views on the value for money we achieve for our spend on private health care versus how the money could be spent on or invested in the public health system.

Deputy Josepha Madigan: I thank Ms Harkin-Kelly for her very comprehensive presentation. Midwives do a significant amount of work and save a significant amount of time for consultants on a daily basis. I have a very strong view on that. It is awful to hear that morale is so low. We are delighted that Ms Harkin-Kelly is before the committee today so that we can try to move forward and find some solutions.

I refer to the plan over 15 years, in terms of changes in technology and medical science. How does Ms Harkin-Kelly envisage the health sector dealing with that? Would a plan have to

be reconsidered after a period of time? How does the INMO envisage the devolution of funding for health care to work? Does it see scope for community providers and not-for-profit organisations to participate? I am interested in hearing the views of Ms Harkin-Kelly on that.

Ms Harkin-Kelly referred to transforming models of care and the very significant expansion of duties for nurses and midwives. I refer in particular to her comments on empowering nurses and midwives to order diagnostic tests. The phrasing is interesting. She did not say that they should diagnose something; rather, that they could order tests. From an insurance perspective - I am veering into the territory of the role of doctors - I would like her to flesh that out for me. I have concerns about that from a medical negligence perspective.

Deputy Pat Buckley: I thank Ms Harkin-Kelly for her presentation. I will not refer to morale and so forth, because we are hearing about that repeatedly. She said people were not being treated with respect within the system. Is it that toxic?

She also mentioned managers not having access to budgets and so on. Surely a person buying a car or building a house knows exactly how much money they have or how much they can play with. I find it extremely worrying that people have no control over expenditure and ask her to elaborate on the matter.

Everything else has been touched on. We all probably have pains in our heads from hearing how bad morale is in the health system.

Chairman: That message has come through clearly all right. I ask the witnesses to respond to the questions.

Mr. Edward Mathews: I can inform Deputy O'Reilly that there has been a degree of progress made in dealing with the skills mix. Our submission has clearly recognised that the proper delivery of care within the health service must be evidence-based and significant work on that has occurred. For instance, there has been very significant work done on the acute medical and surgical area. The task force on staffing has clearly identified that one needs a proper skills mix that looks at the roles played by nurses and midwives, whether they be advanced practice nurses and midwives, specialists or more pertinently, in this context, the staff nurse or midwife and the role of the health care assistant. That work has been done. There is some willingness, it would appear, to move that forward but there is not a sufficient willingness to implement an appropriate evidence-based skills mix. The delivery of care must be evidence-based. It must be based on an acuity and dependancy assessment that looks at the type of patients being cared for, and the appropriate professionals and other health service staff that should be available. They should all be appropriately trained including, as we have said in our submission, the minimum training for a health care assistant within the system and obviously then the regulated profession of the staff nurse and midwife grades.

The Deputy asked whether the blockages could be addressed. There is no willingness to understand and accept, within the system, that reductions in the levels of professionals and the appropriate personnel available to treat patients is causing difficulties such as increased waiting lists and increased emergency department trolley figures. Very importantly, the registered nurse forecasting study, RN4CAST, shows that mortality rates increase when one does not have the right skills mix within a particular work location. I have focused on the medical and surgical inpatient areas. We must also consider the maternity strategy and the requirement for the appropriate number of midwives to birth with a nod to Deputy Madigan's points on the role of midwives, to which we will come back.

The requirement is for an evidence base. Nobody can spend money on the call of a particular person or profession for anything. The evidence base has to be the acuity, dependency or birthrate or both, depending on the area one works in, who are the appropriate professionals to meet that and whether the system then will accept that those staffing levels and staffing mix must be based on patient need and not based on the current budget allocation. We do not have to look too far away to the terrible realities, multiple deaths and significant systemic difficulties that arose in the neighbouring jurisdiction where budgets became the primary driver of what care would be delivered and not the quality of care required. We must move away from that system and towards a system that recognises the minimum level of professionals and other staff that are necessary.

Deputy Louise O'Reilly: I have a supplementary question. Mr. Mathews referenced budgets. Is there scope for savings to be made with a skills mix? I acknowledge it should not only be driven by a cost-saving measure but does Mr. Mathews see that there might be-----

Mr. Edward Mathews: Very realistically, depending on the patient group that is available and what the research says. Every area of the health service should be staffed based on the what the acuity and dependency of the patients demand. That can result in cost savings or a cost increase but must be evidence-based because we have to deliver care on the basis of what evidence suggests, which can be publicly accounted for, and not on what the INMO or somebody else says. It is what the evidence tells us is the necessity for that patient. I wilfully acknowledge that there could be savings but it could also result in a cost increase.

Deputy Louise O'Reilly: I thank Mr. Mathews.

Mr. Edward Mathews: To address whether public and private health care is value for money, it is a misnomer that private health care is cheaper health care. In research we conducted when preparing a health strategy statement for our organisation for the consideration of the public, and in our submissions to the committee and other interested parties, we have looked at the delivery of health care across multiple jurisdictions. One does not have to look too far. One can look to the west to the United States that has a predominance of private health care within the delivery of health care that has resulted in a huge increase and a disproportionate actual expenditure on health care versus a very low delivery.

Let us consider the United Kingdom and the commissioning of care in the private sector. The Care Quality Commission in the United Kingdom has recently sounded significant notes of caution about the ability to regulate and the quality of care being delivered in that jurisdiction arising from expenditure in the private sector. There is also the research in the United Kingdom that points quite clearly towards the fact it is more expensive to deliver care in the private sector.

Professionals who deliver care in the private sector must be procured from an international labour market so they will not be paid a lower rate. In the private sector increased sign-on bonuses are now being offered to registered nurses and midwives that draw recruits away from the public service and into the private sector. The amount paid to the staff will remain the same.

The extracted profit is the *raison d'être* for a business delivering a service. There is no ability, in the same manner, to regulate the delivery of care. We do not believe that the value for money argument holds water. If one says one gets greater value for money, we believe that research shows that it costs more. We believe that the labour market does not support paying people less to deliver the service and, therefore, why should the State be funding an additional layer of expenditure, which is the profit margin involved? We have no difficulty with profit

margins in a general sense but we are here to deliver a health service to the nation, to maintain the health of the nation and to improve the health of the nation. I believe we are illegitimately spending additional money to do so. We do not have any reasonable value-for-money analysis that can point to either higher quality or reduced cost and, therefore, the State should deliver it on a direct employment basis.

I shall hand over to my colleagues who will address additional points.

Ms Martina Harkin-Kelly: Deputy O'Reilly directly referred to the comment I made in my opening statement about the broken spirit of staff. That is the best possible way to describe morale, and Deputy Buckley may have alluded to the matter as well.

In terms of how the committee can garner credibility, the immediate solution is to attract back the people who have gone to foreign fields. As many as 7,500 nurses have gone to the UK alone. We need to incentivise them. We need better remuneration for nurses here in order to retain them. It costs money to train nurses here and then we export them abroad. We must reconsider their terms and conditions and provide ongoing education, training and evaluation. Last night I attended a meeting and the sense of anomie and helplessness in the room was palpable. We must beat that drum and reiterate it because the message has fallen on the deaf ears of Government. Nurses need incentivised packages to encourage them to return home. It may take the form of providing money for rent, travel expenses, moving or further education over a two-year or four-year span. Whatever form it takes it desperately needs to be done and it needs to be done now.

Chairman: What about devolving budgets?

Deputy Josepha Madigan: I raised the issue.

Chairman: A couple of members raised the issue.

Mr. David Hughes: On the question of budgets, we have a situation where public health nursing has moved away from being able to assess needs and then order and deliver aids for people fairly promptly. That function now requires an elaborate business case to be made for everything, which delays the delivery of service. Sometimes one does not get an answer or the process can take months. Unfortunately, the person who needs the aid will have moved to another place or will be gone altogether before the aid can be delivered. Direct heads of service are now unable to command their budgets thus delaying and, in many cases, preventing patient care. The matter must be given great consideration. We have gone from a fairly direct management reporting structure to a very indirect one. Communities have gone from a very accountable system, where local regional health authorities serviced by elected members at least could ask questions about the service being provided, to a situation where nobody can ask any questions. Managers only answer to managers. There is a terrible lack of governance and that has led to a situation where the heads of the service have little or no control over whether they can replace the staff or supply what the person needs. That also happens in hospitals. There is a pushing back, particularly of nurse leaders, in terms of budgetary control and ability to deliver services. That is what has happened.

Deputy Pat Buckley: Let us call a spade a spade. Take the example of a child who goes into hospital for a specific operation and obviously needs a hip spica chair. Is the witness saying that in 2016 people in hospitals in this country do not have the capacity, leadership, accountability or responsibility to deal with that and, despite the child needing a specific chair before

leaving the hospital, they must make a business case and it will take too long?

Mr. David Hughes: That is what happens.

Deputy Michael Harty: I thank the witnesses for attending. I have two questions. Recruitment is a huge, and probably the most pressing, problem in the Irish health service. Earlier, the witnesses from the IMO identified salary as the fourth in priority of wishes of NCHDs to remain in this country. Working conditions, length of contracts and career progression and hope for the future were ahead of salary. Perhaps the witnesses would comment on how those could be addressed. The second item relates to transforming medical care. The witness suggests that all new consultant and GP contracts should be public-only contracts. How do they envisage that working? I can see, perhaps, how public-only consultant contracts can work in a hospital where there are a number of consultants who can take over the care of non-eligible patients. However, I do not see how it would work in general practice, where only 47% of the population has an entitlement to a medical card. If one moves to a single-tier service in which everybody is covered it would be possible to allow GPs to have a public-only contract, but that would not be possible in the current situation. If everybody is eligible, why would there be a contract rather than a salaried position?

Deputy Hildegarde Naughton: I thank the witnesses for their detailed submission and presentation. They indicated that a move to a new model would have to include a review of our bed capacity, particularly in the hospital setting, to address the severe overcrowding and the numbers. I put this question to the previous witnesses. I believe a bed review would have to be conducted independent of the Government and the Department. It is important that we instill public confidence in this. What are the witness's views on this? Do they have a figure? Mr. Mathews referred to it being evidence based. Do the witnesses have an approximate figure for it? What are their views on how the bed review would be conducted?

Chairman: I have three questions. You said that nurses want to take on new responsibilities and duties. What is stopping that? What is your view on the present arrangements, particularly in light of the fact that nurses will be leading on chronic disease management? Currently, that is proposed to be done by practice nurses. What is your view on practice nurses being employed by GPs? Is that the optimal way of providing that service? With regard to the recruitment and retention of staff, over the last few months the potential for having some type of scholarship scheme has arisen, whereby nurse training would be funded and, in return, nurses would commit to staying in the Irish system for three years or whatever other length of time. Do you have a view on that type of approach?

Mr. David Hughes: I will respond on the recruitment issue first. Deputy Harty outlined what the IMO said about doctors. Money is a big issue in the case of nurses and midwives. The overall remuneration package to attract nurses is simply not good enough to get the people who have left this country to return. All OECD countries are facing a huge shortage of nurses and health care workers generally in the next two decades. We are competing in an international market that is offering better terms and we cannot do that. We are even competing in an Irish market where private providers are making better offers to nurses to move to them. It is not realistic; the bring them home campaign showed just how unrealistic the efforts are. Unlike what the IMO said about doctors, money is a major issue in terms of getting those people back to this country and keeping them here.

We have the other issues in common. On the lack of educational opportunity, the last eight years have seen a big pull back on the educational opportunities for new nurses coming into

the system and for existing nurses. There is a huge appetite among nurses and midwives for continuing education, and we see that in the services we provide. However, the funding of that has been left to individuals in many cases and has been pulled back. When we attract somebody back from another country, that is one of the reasons they leave again. They have lost what they had in England or in whatever other country they were in terms of educational opportunity and career progression. Those matters are equally important for nurses, but money is much higher than in the list of priorities the Deputy heard from others.

Ms Martina Harkin-Kelly: In addition, unlike the case in the medical profession, the Nurses and Midwives Act 2011 does not set aside studies times for nurses. Many of the nurses and midwives carry out ongoing and continuing professional development on their days off. The only leave they are given at present, and even that is being pushed, is for mandatory training. That is the reality of the vagaries that exist in the system.

Mr. Edward Mathews: On the question about the new responsibilities and duties that nurses and midwives have assumed in many locations and the necessity for greater progression, the blockages are twofold. One is a systemic unwillingness to recognise the full contribution that nurses and midwives can make in specialist and advanced practice roles. The international research is clear regarding the ability of nurses and midwives in specialist and advanced practice roles to manage both complicated and uncomplicated care in a variety of settings, be it primary care, acute care, elderly care or mental health, and the ability to do that, which in turn increases the positivity of patient experience, has been shown to reduce hospital admissions and increase the integrated nature of the care. That is the big block within the silo system we have at present, which ultimately is leading to people not getting the care required and is leading, in turn, to the incredible pressure in the secondary and tertiary systems.

Chairman: I take it that principle is not being recognised by the HSE management.

Mr. Edward Mathews: Absolutely, it is not being sufficiently recognised. It must be recognised. That is one element of it. The other element is the tortuous process that has grown organically for the development of advanced practice roles. We must move to the model that has been implemented in other jurisdictions, which is a credentialing framework using the nursing and midwifery register. This recognises the skills and competencies that are available in the graduate workforce, recognises and supports the ongoing education of people and experiential learning, credentials that, that is, annotates it to their register, and allows them to progress to the advanced practice role. It must be within the HSE service plan or that of whoever or whatever will manage the health service into the future, in our recommendation the health authorities with the Department of Health having the policy lead, to embed advanced practice roles within the delivery of care across the models of care to ensure that people get the right professional at the right time delivering the right care. It involves the credentialing framework and the willingness of the system to deliver that.

In tandem with that, I will respond to Deputy Madigan's point which is a concern relating to, perhaps, a medical negligence issue and the advanced practice role. Quite simply, the issue does not arise. The standard of care that must be delivered is based on the level at which the practitioner is operating. When people reach an advanced practice role, international research and all of the safety literature show that those advanced practitioners are competent and capable to deliver and manage care, both complicated and uncomplicated, across a range of headings and to be competent and capable to discharge people and cross refer between services and professionals and between advanced nurses and physicians, to ensure the delivery of the care that is required.

On chronic disease management and the role of practice nurses, as I said, there is an absolute necessity to have nurses embedded at specialist and advanced practice level to ensure the proper delivery of chronic disease management, which is the issue of our time, particularly in the context of the possible doubling or more of the elderly population and changing demographics as we move forward. Practice nurses should not be privately employed. They should be employed by the public health system. If we are to have an integrated delivery of care, we must have a managed and delivered service within which people are working as part of a team rather than employed by somebody else and siloed off in a separate location. These people must have access to the supports and systemic advancement opportunities which come within the public health service that we are envisaging, such that a practice nurse working at a particular level automatically progresses to a specialist or advance practice role, be that in chronic obstructive pulmonary disease, cardiac epilepsy and so on, in respect of which there are good models throughout the service. Currently, there is no standardisation within the service to allow that type of progression.

Chairman: If we had a big bang in terms of a move to a totally public system, that would be a different matter, but in terms of a transition to a new type of system, there are GPs who want to continue in private practice, single-handed or group practice, and employ practice nurses. Would Mr. Mathews envisage their being able to continue to do so in a transitionary phase?

Mr. Edward Mathews: The committee is aware of our view in regard to a publicly delivered service in the future. Our view is that there would be no reason those practice nurses could not be brought within the public service and allowed the opportunity to benefit from the integrated team approach. There is a difficulty where a siloed individual is providing care. It is possible that, with agreement, such a person could be brought within the public service, thus leading to increased availability of the team approach, increased integration and access to the other professionals within the primary care service, including the ability to cross-refer. These people should be brought within the service to maximise integration within the transitionary phase. Otherwise, they will remain isolated where they are currently.

Chairman: What is Mr. Mathews's view on a scholarship scheme?

Ms Martina Harkin-Kelly: The issue is not one of training. There are people applying through the CAO system year-in, year-out, for nurse training. The retention of nurses following training is the issue. As mentioned by Deputy Buckley, there is a misnomer with regard to what a nurse is trained to do over the four-year training timeframe. Such a person is a graduate degree student who progresses to higher diploma, Masters and, in many cases, PhD level. It is not the four-year training period that is problematic but the immediate period after that four years.

However, I caution against any scholarship scheme in respect of which there would be no stipulation with regard to salaries post training. As a union we believe that nurses should be paid at the same salary level as all other allied health care professionals because they have the same qualification. There is no difference in this regard. I would go as far as to say they are the most holistic individuals who sit within the health service in that their role is physical, psychological, social, spiritual, environmental and economic. That is what they are trained to do.

Mr. Edward Mathews: The issue is one of emigration. There are elements of emigration that have always occurred in terms of health professionals from which we have all benefited. The difficulty is the net migration figure, which has not resulted in people coming home. The difficulty with a scholarship scheme is the inherent inequity and unfairness of people being trained and provided with a level of education in respect of a particular occupational group be-

ing disadvantaged because the terms and conditions are such that they would not be retained but would be instead indentured into the service. What we need are the terms and conditions and work environments that people want to work in.

We must become an employer of choice. An employer of choice in nursing and midwifery has proper terms and conditions of employment and comparable working hours with other health professionals. One of the greatest barriers for our colleagues is the availability of a reasonable and certain career progression ladder. They must have opportunities that allow them to move to a specialist or advanced role. Our graduates will be on Skype interviews with London hospitals offering them immediate specialist placements, immediate education and immediate advancement. They will also be on Skype interviews with New Zealand and other jurisdictions such as Australia, Canada and the United States, all immediately offering them jobs while here they cannot get a promise that they can even work in a particular department for a particular period, never mind a promise that they will have opportunities for career advancement. We need to address those issues and become an employer of choice. We need people who want to work in our system rather than people who are indentured to the service.

Mr. David Hughes: In regard to the scholarship, there is one area where it could be of benefit but in which it has only worked to a limited degree because the numbers allowed to participate have been very small, namely, people who already work in the health service. There is a scholarship scheme for people training to be nurses in the care delivery area, although the funding in this regard has been reduced. There is potential in terms of the number of people who could progress successfully under a scholarship in the mature existing health care occupational group area.

Deputy Michael Harty: Perhaps the witnesses would address the issue of public-only contracts for consultants and GPs.

Mr. Edward Mathews: There is a transitionary period within the delivery of health services. Our vision is for a publicly delivered primary acute mental health and social care service. It is within that context that we have recommended the public-only contract. We believe that if the goal is to have delivery of an organised and integrated service where everybody is rowing in the same direction under the same policy, we cannot have people who are not within that service. That is our view. We do see a transitionary issue arising in terms of eligibility, but we want to move towards universal eligibility within the primary health system. That is how we would address the issue.

Deputy Michael Harty: In regard to GPs with a public-only contract, surely there is not much of a jump between that and a salaried GP. What would be the advantage of a GP having a public-only contract and not being salaried?

Mr. Edward Mathews: I do not necessarily think that there is any particular difference. I am not sure there is much between us. We believe that GPs should be within the system. In other words, they should be employees within a salaried system. Perhaps it is a matter of nomenclature rather than particular difference within the system, if the Deputy gets my point. We would rather a GP be a salaried person within the service. We recognise that there are currently a cohort of GPs who are in private practice. The issue is how those people would be brought into the system and how those who do not want to come into would be allowed to continue to have their contractual rights during the transitionary period. Into the future we would see all deliverers of service, including GPs, delivering service in the same way as consultants do.

Deputy Hildegarde Naughton: Perhaps the witnesses would address my question on additional bed capacity and the independent review.

Mr. Edward Mathews: We have no difficulty with such a review. Our belief is that the public must have confidence in the delivery of a service. We have said very clearly that no single group, no single occupational category or single influencer can act as a vested interest to block either the future advancement of the service or to influence the service unduly in the future. In that context, we believe there should be the equivalent of a public health inspectorate to monitor delivery of care and ensure value for money, such that in regard to money devolved at unit level there is no free-for-all but an obligation to operate from an evidence base in relation to staffing numbers.

On the Deputy's question regarding the independent review, as I said, we have difficulty with a review. We can look at the OECD average of 2.8 versus 4.8 per thousand of population, the loss of 2,000 beds and the recommendation of a former Minister for Health in the context of previous reductions in bed capacity of a cushion of six co-located hospitals with up to 400 beds each, which never materialised. We have no difficulty with or fear of an independent bed review. We know we must reduce the number of patients who are fit for discharge and should not be in the hospital but it is our belief, and the evidence will show, that pending moving to a more integrated primary service, there is a need for more acute beds. That is why we are recommending the higher spend in the interim period. We have no objection whatsoever to an independent study which receives submissions from interested parties and reaches determinations. The OECD figures point to the necessity for that and, if nothing else, the emergency department figures can leave no one in doubt, as do the waiting list figures, that there is a need for a mixed in-patient bed capacity, both five-day and over seven days.

Deputy John Brassil: Whether it is anecdotal or otherwise, I hear that the package available to nurses in the UK, Canada and the USA is far better than is available in Ireland. Do the witnesses have a set of figures on starting salaries for Irish nurses and midwives versus those in the UK so that the committee could have a benchmark? My niece qualified recently and, thankfully, has got a job as a midwife in Galway. She is very happy with her permanent job and has no intention of going anywhere. There are examples of students and people who want to stay in Ireland and are happy to do so. I do not expect the witnesses to have the figures, but they might follow up the meeting by sending the information so that we could look at something factual rather than anecdotal.

Mr. David Hughes: International comparisons are notoriously difficult because the cost of living influences what one earns. ICN carries out an international comparison based on PPPs which gives one the value of an income. There is a lot of that information. We can make direct comparisons with the recruiters.

Deputy John Brassil: I emigrated in the 1980s. I knew the salary I had in Ireland and the salary I was going to in the UK. One can make a fairly-----

Chairman: Those figures with purchasing power would be the relevant ones, in particular in relation to housing. Whatever about the Deputy's niece living in Galway, Dublin is prohibitive because of the cost of housing. One must factor in the cost of living with salaries.

Mr. Edward Mathews: We can certainly provide the comparative.

Chairman: We need starting salaries but also the scale in terms of how quickly or otherwise

a person progresses.

Deputy John Brassil: The cost of living in Australia and Canada is substantial as well.

Mr. Edward Mathews: There is no fear in having the purchasing power figures and the actual figures. The committee will have both and will then be able to make the comparison.

Chairman: Yes.

Deputy John Brassil: It is good to have them so that we know what standards we are trying to set.

Mr. Edward Mathews: Absolutely. There is no subterfuge. The data is there and we will happily provide it along with the purchasing power figures which are a relevant factor, as well as the raw analysis of the actual figures. Certainly, we will provide that to the committee.

Deputy Louise O'Reilly: There is clearly an issue because people are leaving. It might be the salary and it might be something else. Purchasing power figures would be useful for comparison. We can compare the basic payscales also. However, there are other factors at play. Is it career progression, staffing levels or morale? What is causing them to go? It cannot just be money.

Mr. Edward Mathews: Deputy O'Reilly has a point. To provide a fair analysis and a fair answer to Deputy Brassil's question, we will need to put to the committee not only the raw figures and the purchasing power figures but also the points we raised about automatic access to career progression, automatic access to specialist working areas, automatic progression to specialist and advanced practice roles, lower staff-to-patient ratios and a much-improved work environment. We have objective data and subjective perceptions which are equally relevant and valid because people are leaving. We can provide both to the committee to assist in its understanding of the overall situation.

Mr. David Hughes: At the moment, the poor work environment is crucifying those in it and driving many out. It is appalling in terms of the workload, pressure and inability to control the numbers who come at the service. The nurse, midwife and care assistant working with them are the ones who take all of that. It keeps on coming. It is an appallingly bad workplace and many who look at it externally will not go into it. They ask why they would go from their workplace to this one.

Chairman: The Medical Council surveyed doctors on the reasons and Deputy Harty referred to that earlier. It was very interesting for us to hear the results of that survey. I do not know if the INMO has surveyed its members in that regard, but we would be very interested to see any information it has on the underlying causes.

Mr. Edward Mathews: Absolutely.

Chairman: I thank the witnesses for their very significant contribution to the work of the committee. We appreciate their time.

The committee adjourned at 12.45 p.m. until 9 a.m. on Wednesday, 9 November 2016.