DÁIL ÉIREANN

COISTE UM CHÚRAM SLÁINTE SA TODHCHAÍ

COMMITTEE ON THE FUTURE OF HEALTHCARE

Dé Céadaoin, 22 Márta 2017

Wednesday, 22 March 2017

The Joint Committee met at 9 a.m.

MEMBERS PRESENT:

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

DEPUTY RÓISÍN SHORTALL IN THE CHAIR.

Health Service Reform: Minister for Health

Chairman: I remind everyone to ensure his or her mobile phone is turned off for the duration of the meeting to ensure there will be no interference with the recording and broadcasting system. I welcome those watching our proceedings online.

On behalf of the committee, I warmly welcome the Minister for Health, Deputy Simon Harris, who is accompanied by the Secretary General of the Department, Mr. Jim Breslin, as well as by Ms Laura Casey and other officials. The purpose of the meeting is to allow the Minister to have an input into the committee's work and outline his views on possible reforms.

The Committee on the Future of Healthcare was established in June 2016 because of a recognition that cross-party political consensus was needed in order to reform the health service. A key objective is to devise a ten-year plan to reform the service. The committee's terms of reference also emphasise the need to establish a universal single-tier service in which patients will be treated on the basis of health need rather than ability to pay. A consensus-based approach has been adopted to all of our work. In order to help to achieve this, the committee has held a number of workshops in recent months. Since last June we have consulted widely on a range of possible reform options. The committee is working with a team of health policy researchers from the centre for health policy and management in Trinity College Dublin to examine international evidence on universal health care systems. Since our establishment, we have consulted a wide range of people and groups, including national and international health policy experts, a large number of patient organisations and several professional groups.

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. However, if they are directed by it to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter only to 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 asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or an 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 that they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable.

I again welcome the Minister and invite him to make his opening statement.

Minister for Health (Deputy Simon Harris): I thank the Chairman and members of the committee. I welcome the opportunity to set out some of my views on the future direction of health policy. We all know the challenges that we face in the area of health and that these issues have been with us for many years. We also know that it takes time to give effect to reforms in the health service. I believe that, for a variety of reasons, there is a certain amount of reform fatigue, one of which is certainly the absence of a long-term plan founded on the consensus necessary to have confidence in its delivery. That is why I was so strongly supportive of the commitment in the programme for Government, the commitment of all parties in the Dáil and, in particular, that of the Chairman, Deputy Róisín Shortall, to establish this committee to avail of the considerable advantages in having broad political consensus on the strategic direction of reform. Of course, the Minister of the day has responsibility for setting policy and should be and is accountable to the Dáil. However, if we can achieve consistency of approach at a high level for a period of years, we can improve the position for patients, their families and the many

dedicated staff who work in the health service.

I await with great interest the outcome of the committee's deliberations. As members know, there are certain issues such as those related to system governance and the finalisation of a five-year HSE service plan, mentioned in both the confidence and supply agreement and the programme for Government, on which I have deliberately not moved until I have the benefit of the committee's work. However, I have now been Minister for the best part of a year and have a strategic perspective on these and other major issues which I would like to share with the committee in the hope that it will be of assistance. Genuinely, it is in that spirit that I am here. While I wish to share my views and perspectives, what is most important to me and all members of the committee in the work they have been doing is that we arrive at a political consensus. For what they are worth, these are my views, but reaching political consensus is of paramount importance.

The report of the committee and the work that will follow will be significant for the country. This is the last chance for a generation to get it right. We all know the compelling reasons we have to make the most of this chance. I will elaborate further in the course of this statement on each of the priorities which I believe need to underpin the future direction of health policy, but, broadly, they include a shift in the model of care towards more comprehensive and accessible primary care services; an increase in health service capacity in the form of physical infrastructure and staffing to address unmet needs and future demographic requirements of citizens; exploiting the full potential of integrated care programmes and eHealth to achieve service integration based on the needs of patients across primary, community and acute care services; strengthening incentives for providers to respond effectively to unmet health care needs by ramping up activity-based funding; empowering the voice of clinicians and providing them with opportunities to contribute to the management of health services; further developing hospital groups and community health organisations, aligning them geographically and, as they develop, devolving greater decision-making and accountability to them; following this with the provision of a statutory basis for hospital and community health organisations, operating as integrated delivery systems within defined geographic areas; and, once statutory responsibilities and accountability have been devolved from the centre to hospital and community health organisations, dismantling the HSE and replacing it with a much leaner national health agency. In the interim, because we cannot wait for all of this to happen, we need to reform the existing legislation within which the HSE operates to improve its governance structure.

It is important to place Ireland's experience of health service delivery within a comparative international context and take a long-range view. That is not to say, however, that we can simply adopt another country's health service, but through comparisons we can learn about ourselves and our strengths and weaknesses. In the past, attempts have been made by reputable international bodies with health expertise to rank health systems. I have referenced a number of comparative exercises in my full statement which I will take as read. First, we compare well on health status. In particular, life expectancy has increased by five and a half years over the past two decades in this country. Second, we have relatively high levels of reported unmet needs and the main reason for this is the cost of health care. I believe this is confirmed by our own experiences as public representatives. The biggest challenge facing our health service relates to coverage and access.

Over the past few months, I have made no secret of the frustration that I felt, and I am sure members of this committee feel, at some of the problems our fellow citizens face in accessing health and social care. I say health and social care because problems of access are not confined

to surgery or unscheduled hospital care. Access is also an issue in respect of community-based services.

In line with the key theme that has emerged from this committee's consultations, I believe we must find a way of bringing about significant improvement in access. We should do so without losing focus on other crucial goals such as patient safety, efficiency and cost-effectiveness. The overarching objective must be population well-being and disease prevention or what we now refer to as the healthy Ireland agenda.

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

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

The third point I would make is that there are many disparities in the way in which we, as citizens, experience health care. Health inequality is a major issue. It will become even more marked in the years ahead unless we find ways to serve all of our people better. This will require us to pay greater attention to addressing differences in access and outcomes as a central part of ongoing performance evaluation and to work with other sectors, nationally and locally, to address underlying social issues that impact on health and well-being.

I mentioned at the outset that I have not moved ahead with structural change or changes in HSE governance in deference to this committee's work. I am not a believer in structural change just for the sake of doing so and it has not proved a panacea in the past. However, if our structures are not best serving patients, then change they must. I must stress that when I talk about HSE structures not serving patients or others in need of services, I am not talking about HSE staff. In fact, I know from my interactions with staff that they suffer negative impacts by structures that place too many layers between health service leadership and front-line staff.

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

The key entities for managing service delivery that are now in place in the Irish health service are hospital groups and community health organisations. These are at different stages and both require significant further development. This will bring decision-making closer to the point of care delivery and will provide a counterweight to the over-centralisation of decision-

making and accountability that impedes service responsiveness.

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

The next stage would be to provide a statutory basis for hospital groups and community health organisations. Rather than do this separately, it is my view that we should legislate for integrated delivery systems within defined geographic areas that, for now, I might refer to as hospital and community health organisations. What I am outlining here is a clear journey towards a more devolved, responsive and integrated delivery system, although I acknowledge it will require time and careful planning. An integrated approach will enable us to move beyond the silo mentality and structures that often exist in the delivery of current health services.

My Department is on the record as saying that the current HSE directorate governance arrangements, as set out in legislation, need to be reviewed. While this committee is developing a ten-year vision for the health service, and this may, I would imagine, and I hope will result in significant change, including legislative change, in a number of phases, I respectively suggest that more immediate improvement in existing national governance arrangements is merited. Subject to the committee's report, I intend to ask my Department to come forward with proposals to improve governance arrangements for the HSE for so long as the HSE continues in its current form. This will include examination of the current vesting of governing authority in the HSE directorate, including the fact that the director general is currently responsible to the directorate for the performance of his or her functions. Many members of the directorate, however, are actually subordinate to the director general. We really need to take a new look at this matter. I do not think we need to wait for the end part of a ten-year strategy to move ahead with this matter and I hope that we can develop a political consensus on that. However, with the development of stronger, more accountable and geographically aligned providers, the opportunity will arise to begin to more fundamentally consider organisational arrangements at national level. The overall HSE project initiated in 2005 can be legitimately criticised in a number of areas but the need for national arrangements for planning and sharing of expertise and services for a population of less than 5 million people cannot.

We have gained much in recent years through national initiatives in areas such as the cancer programme, the integrated care programmes, the fair deal scheme, eHealth and other areas. We need to retain such capability and avoid reverting to stand-alone geographically based organisations in the mould of the old health boards. However, the national health capability that takes the place of the HSE is likely to be a much slimmed down body. In my view it is likely to be more equipped to lead than to directly control and, accordingly, with fewer management layers between the top and the front line.

There is also a question as to the respective roles of such a body and the Department of Health. In some countries of not dissimilar size, such as Scotland, the Department itself commissions services from regional providers but in others, an organisation at a remove from Government of the day, and the Civil Service, plays this role nationally. I genuinely have an open mind on the question of where such a national agency should sit in terms of the Department. I

would appreciate input and guidance from the committee in that regard.

The challenge in any set of proposals is to devise a clear set of principles and a framework of accountability that ensures better and more rapid decision-making and responsiveness. They must also fully recognise the demands of parliamentary accountability.

I am sure all members are familiar with the demographic and epidemiological challenges this country faces. These challenges are common to the vast majority of developed economies. I shall not go over this matter in detail this morning, although I have elaborated a little further in my full speech that has been circulated. As things stand, the annual increase in the number of people over the age of 65 in Ireland is approaching 20,000. The overall number in this age group is expected to increase by more than 36% between 2016 and 2026. What this all means is that the nature of the demands that the health service must provide for has changed. Today, the great challenge is the management of chronic disease. These are long-term conditions that can be treated but not cured. In some respects, chronic disease is simply a feature of living longer but in many other cases the onset of disease is influenced by lifestyle factors such as diet, exercise, smoking and alcohol consumption.

As chronic diseases are often managed rather than cured, this shift in the burden of disease requires a shift in the way that health care is conceived, provided and managed. Traditionally, health services have been structured to provide episodic care but we now need a far greater emphasis on continuous care. That is why the World Health Organization has placed so much emphasis on the development of person-centred and integrated care, which is care that is organised around patients and not just around groups of conditions or around health facilities such as hospitals.

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

Many of the necessary features of the new model of care are already apparent and some are already being put in place. First, because chronic disease is related to lifestyle, we need to drive ahead with the healthy Ireland agenda. As a country, we have made considerable strides in tobacco control, and there is a growing consciousness of the need to have healthier diets and take more exercise. However, we cannot be complacent; we must drive ahead with implementation of our strategic approach. This includes public health measures targeted at discouraging harmful levels of alcohol consumption.

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

As we look to develop more comprehensive and integrated primary care, we need to consider the challenges which experience has shown us we are likely to encounter. Achieving a high level of teamwork across diverse professionals with different employment and contractual relationships, priorities, cultures and approaches has proven to be challenging. It has not always been easy to combine the efforts of salaried HSE staff and general practitioners paid through capitation for medical card holders and fee per visit for others. Coverage and eligibility have also been issues. For example, how can the role of primary care in population health, disease management and hospital avoidance be fully realised when the State's financial support is predominantly concentrated on paying for access for the one third of the population on the lowest incomes? Also, in introducing improved primary care facilities, we now have examples of very successful primary care centres but we have faced problems in some areas with GPs locating in such centres.

While these challenges are closely related to our existing organisational, contractual and eligibility arrangements, all health services seeking to promote primary care face the twin challenges of achieving successful team-based, multidisciplinary working and enhancing the status of primary care professionals within the overall health service. Let me be clear: despite these challenges, augmenting primary care services is central to any successful strategy to address health care needs and to promote population health. I will be very interested to hear the committee's considered views on how the vision of enhanced, more integrated primary care can be achieved and the challenges in doing so overcome.

I suggest we can build upon important developments in the primary care arena in recent years. These include the extension of eligibility for GP cards to children under six years, the development of the diabetes cycle of care and the ongoing investment in the physical infrastructure of our primary care. Over the next ten years, however, we will have to significantly expand the scope of our ambitions as to what can and should be delivered in a community and primary care setting. This will involve investment in people, buildings, diagnostics and training as well as, crucially, expanding the scope of eligibility for primary care services on a phased and prioritised basis, taking account of resources and capacity within primary care. If we do not address this, we will continue to have a primary care system whereby the State's crucial link is to provide cover for a third of the population but not to provide financial support for the other two thirds.

As the committee is aware, we are at the early stages of negotiation of a new contract for GPs. This is an important piece of work but is by no means the only element of the transformation we must effect.

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

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

We must also consider how services which are currently hospital-based can be deployed in community settings. Community intervention teams and the maternity strategy are two good examples, and there is a little more on both in my full written statement.

Hospital groups will enable better configuration of hospital services with benefits in respect of safety, quality, access, cost and sustainable medical staffing and recruitment. Hospitals working together will be able to support each other, providing a stronger role for smaller hospitals in delivering less complex care and ensuring that those who require critical emergency or complex planned care are managed in larger hospitals.

The evidence for how hospital services should and can be organised in a manner that achieves quality and sustainability is now being confronted by health systems the world over. Medical technology and practice and global competition in training and retention of highly skilled health practitioners are all reshaping our hospital services. However, as politicians, we have on many occasions been hesitant in interpreting and reconciling these unavoidable factors with the existing understanding and expectation of the public we serve.

We cannot simply rely on clinicians to explain to the public how the reality of hospital care is changing and set to change further, not just in Ireland but in every health service committed to achieving above all else excellent patient outcomes. The committee had the benefit of hearing from the very eminent professor Tom Keane, who contributed so much to the progress we have made in cancer care. Professor Keane gave very well-deserved credit, in my view, to the political leaders of the time who initiated and provided crucial support for these reforms. Such credit is overdue because some of these political leaders were at the time the subject of unrelenting criticism in this House and outside from a range of political parties, including my own. I believe the committee, through its final report, has an important opportunity and, I would respectfully suggest, a duty to explain these developments so that future Ministers for Health have greater support than heretofore to do the right thing on the basis of sound health policy. In the era of "new politics", without such support, the change necessary to deliver ambitious improvements in our health service as envisaged by the committee risks being severely hindered. The recently completed report on the Northern Ireland health services, called Systems, Not Structures, summed up the challenge as follows:

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

That is the view in Northern Ireland. I believe the setting up of this committee was a vote for the former on our part.

I talked earlier about the importance of comparative analysis of the strengths and weaknesses of the Irish health service. The extent to which public and private are interwoven in our health system is one of its most distinct and sometimes controversial aspects. Our publicly funded hospitals deliver care to both public patients and private patients. As far back as 1999, in the White Paper on Private Health Insurance, the potential drawbacks to this mixed system were outlined and these concerns expressed. Nevertheless, in the interest of putting all the facts on the record, the White Paper also identified certain advantages of the coexistence of public and private practice in public hospitals. These are set out in my full written statement. In the intervening period, concerns about the allocation of scarce public hospital resources to private patients have grown. This is partly attributable to the heightened concern about access for public patients generally. It may also be indirectly influenced by the growth in private health insurance coverage from 1.5 million people, or 42% of the population, in 1999 to 2.1 million

people, or 46% of the population, in 2015. Over the intervening years, there have been proposals to eliminate private practice in public hospitals entirely on the one hand and, on the other, through mandatory competitive private health insurance, to extend private insurance to the entire population. Whatever the direction of change, it requires careful consideration as it is likely to have a very extensive implication for hospital costs and resourcing as well as contractual and remuneration arrangements for hospital consultants. Other more detailed aspects of current arrangements are worthy of consideration, including the misalignment of financial incentives, as between public and private patients. At the moment, public hospitals receive a block grant for public patients and a *per diem* rate for private patients.

Movement to activity-based funding for public patients will see public activity remunerated on a per-case basis. It would make much sense and is certainly worthy of consideration in this context to introduce a case-based charge for private patients and to equalise the tariff for public and private patients based on the efficient economic cost. This would eliminate a concern expressed by many that the hospital would have an incentive to accommodate more private patients. Full alignment of incentives would also require a movement away from fee-for-service payments to hospital consultants for private patients towards an annual remuneration inclusive of both public workload and the permitted and planned level of private activity.

I offer these as examples of how the detail of any change proposed in current arrangements will need to be thought through carefully because of provider issues, not least the fact that almost half the population has private health insurance and very many people with such insurance currently receive their care in public hospitals. Wherever the political consensus lands is appropriate, but we do need to make those decisions in the context of these facts.

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

A strength of our primary care system compared to some others is that there are generally no delays in accessing GPs, although there can be issues in some parts of rural Ireland and some deprived urban areas in this country. The responsive nature of general practice owes something to the strong financial incentives under the capitation-based choice of a doctor scheme for medical card holders and the fee for service for private patients. In contrast, the traditional block grant approach to hospital funding entails very weak financial incentives for productivity.

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

A crucial aspect of quality and appropriateness is integrated care. As we change hospital services and strengthen primary and community services, we will be challenged to ensure services are designed around patients, rather than the institutions that provide them. Across the world, health services are grappling with the question of how services can be integrated in order that patients' needs are managed holistically and in as seamless a manner as possible. This will not be easy to achieve - there is no magic wand for integration - but we are working to find the right path for the future. In this regard, I refer to the integrated care programmes. As members will be aware, the HSE is developing a number of integrated care programmes, which are focused on piloting new ways of working within the health service. The integrated care

programme for older people has put in place a number of local initiatives on pilot sites. The integrated care programme on chronic disease is developing four projects which include asthma, chronic obstructive pulmonary disease, COPD, heart failure and diabetes models of care, again focusing on multidisciplinary teams. As insight is gained from these projects, translating those lessons into the broader health service will be one of the big concerns of the next decade. The integrated care programmes are a great example of the benefits of clinical leadership in reshaping our health services.

As a society, we greatly value clinical judgment in relation to our personal health and that of our family. It flows from that value that we must ensure we empower the clinical voice within the health service and facilitate a greater clinical role in health service management. Clinicians in management roles should not be the exception to the rule but rather one of the legitimate options for management of our hospitals and health services. This will involve the development of a range of opportunities and pathways for clinicians to get involved in management. I am struck, when visiting health services, by the palpable frustration of clinicians who feel their voices are not heard in hospital decision-making structures.

A significant amount of the work done in the health service consists of collecting and using information, yet the health service is a long way behind other sectors in society in using information technology. I am aware the committee has given this matter serious consideration and we are making progress on the individual health identifier and electronic health record. A clear strategy and programme of work are now in place and I look forward to these interacting with the outcomes of the committee's deliberations.

I refer again to the issue of capacity. I have repeatedly made clear that increasing capacity is a priority. This includes physical capacity, the staffing capacity to support this and harnessing untapped potential in the system. My Department is managing a large capital programme, much of which involves the necessary replacement and upgrading of existing buildings, rather than adding to the capacity of the system. This is an unfortunate consequence of the age of our health service facilities. While managing this problem, we must also address the question as to what is the level of capacity required into the future, which is the reason my Department is working on a capacity review. Unlike previous reviews, this capacity review will extend beyond acute hospital beds and will examine issues such as the provision of additional capacity in primary and community care. This is the right approach which is also in tune with the thinking emerging in the committee. While we need to have a view on capacity, it cannot be divorced from the need to shift the model of care that is more integrated and continuous, person-centred and delivered at the lowest level of complexity consistent with patient safety. It misses the point to argue that more hospital beds are the exclusive answer. It is within this context that the capacity review will be undertaken.

I am also on record as stating there is no point in increasing physical capacity if we do not have the necessary staffing. I acknowledge the intensive efforts of staff, management and the HSE who work daily to ensure those in need of services receive the highest possible quality of care. I am acutely conscious of the challenging staffing environment our health services are facing. Many initiatives are under way to improve staffing levels and we will continue with these efforts. Increasingly, we operate in a highly competitive market for attracting and retaining many health professionals who are in short supply globally. This is obviously relevant in assessing both pay and tax rates. However, it also means we must enhance the attractiveness of the work environment with ongoing learning and career opportunities. In return we should expect approaches to flexibility and change which are comparable to those demanded of health

professionals in other health care systems, both abroad and in the private sector. All of this will be required to achieve the vision set out on the establishment of the committee. Whatever our direction of travel, the capability of our health workforce - health professionals, administrative staff and managers - will be essential to the success of the committee's proposals.

While I appreciate I have covered a wide agenda at some length, it is difficult to do so in a shorter time. Having followed the work of this committee for a sustained period, I wanted to share with members my insights from my perspective. The work of the committee to date has highlighted the considerable consensus around some of the key building blocks and we can all accept that this will require transformational as opposed to piecemeal change. The challenge for the committee now is in determining the implications of each of its recommendations, what can be achieved realistically in the time period and in what sequence. This involves prioritisation and, where progress will be resource-dependent, consideration of cost. This is no small ask but, through success, the committee will provide the reference point for successive Governments and Dálaí in implementing real change in how members of the public experience health services.

I wish the committee well in its final deliberations and, once again, I offer it my continued assistance and that of my Department as it finalises its work. I sincerely thank the Chairman and members of the committee for the non-partisan and dedicated way in which they have gone about their work to date. This is also the way in which I try to go about my work. I thank members for the opportunity to present my views today.

Chairman: I thank the Minister for his comprehensive statement. We will take contributions in groups of three members. As we have a full programme of work, I ask members to adhere to the agreement that contributions will be limited to three minutes. The first group of speakers will be Deputies Billy Kelleher, Hildegarde Naughton and Louise O'Reilly.

Deputy Billy Kelleher: I welcome the Minister and his officials and the contribution in which the Minister set out his views. Are the views he expressed consistent with the view of the Department or are they personal? I would like to find out whether there is broader support across the administrative system for the Minister's proposals and the views he expresses.

The Minister referred to hospital groups, community health organisations and geographical compatibility. When he speaks of top-slicing the Health Service Executive and giving more dispersal to hospital groups, the key issue is who will be the future employer of staff. The number of staff employed by the HSE when section 38 organisations are included is substantial, standing at approximately 127,000. Will hospital groups become the employer in future or will staff be retained in a broader, larger national administration?

On hospital groups, when a hospital closure or withdrawal of a hospital service is proposed, often on the basis of clinical evidence, a HIQA report or guidance, politicians very often assume the role of advocating for members of the public. In doing so, they do not necessarily advocate for hospital safety or patient safety. If we are to develop a system, it must be sufficiently robust to withstand this type of influence, while also providing some form of accountability to a specific entity. The democratic process needs to be engaged but this must be done without political interference, which was one of the failings of the health board system.

Does the Minister have a clear view of the geographical competencies of the hospital groups and community health organisations? There is no doubt that decisions must always be based on clinical rather clinicians' reasons because there is a fundamental difference between the former

and latter, as was clear in the process by which hospital groupings were proposed and various hospitals linked, which was not necessarily always based on clinical factors but for reasons related to clinicians. We need to be conscious of this issue.

The Minister is correct that clinicians at all levels are frustrated by a lack of access to or say in management, even at ward level. I ask the Minister to elaborate on how he envisages greater clinical input being achieved in the management and delivery of services.

Chairman: I ask the Deputy to conclude.

Deputy Billy Kelleher: If we are to top-slice, perhaps we should address the large numbers of staff being consistently recruited at the top levels of the HSE directorate. I understand the number of staff at this level has surpassed the level at which it stood before the crash. Is it reasonable to continue to do this? Finally, what type of organisation does the Minister envisage for running the national framework? Would it be a slimmed down body similar to the National Roads Authority model, a streamlined body that would just guide national policy and let the hospital groups implement it?

Deputy Hildegarde Naughton: I welcome the Minister and thank him for his comprehensive presentation. I note his comments on the importance of listening to the voice of the clinician, particularly the clinical director, and the importance of empowering that voice. Will he expand on that? The 2008 consultants' contract includes a reference to giving the clinical director executive powers, authority and accountability over developing and planning services and managing the allocation of resources. Will the Minister discuss the powers of the clinical director in respect of budgetary decisions and how that would work? As he said, many of them are frustrated with their role as they do not feel they have enough powers.

The health sector capacity review is very welcome. The committee was provided with a response from the Department relating to the scope of that review. There are at least ten public servants on the steering group as well as two academics in the health service. It is important that the capacity review would be independent of the HSE so people can have confidence in its outcome. I am aware that a review group of international experts will examine it, but I anticipate that they would only be validating the findings of the group. It is important that the review is carried out independently so people have confidence in it. Will the Minister comment on that?

I welcome the Minister's comments on the importance of the governance structures and realigning the CHOs. The two big issues for hospitals at present are managing both the inflow of patients and the egress of patients, which is happening in the community and primary care setting. That alignment must take place to have optimum management of patient flows, so I welcome the Minister's views in that regard. I also look forward to his comments on the capacity review and the role of the clinical director and how he sees that being rolled out in our health services.

Deputy Louise O'Reilly: I welcome the Minister and his officials. One of the terms of reference of the committee is the need to establish a universal, single-tier health service where patients are treated on the basis of need rather than ability to pay. I do not see how that fits with what the Minister says with regard to performance incentives and his heavy-duty reference to the private sector. It appears that the Minister is alluding to continuing with the *status quo*. While we are examining a universal, single-tier health service that is available when people need it, the Minister is talking about private health insurance and private patients in public hos-

pitals. That is a concern. As I have told the Minister on a number of occasions, I believe that while we are working in this committee and doing our best to produce a good report that will inform policy and strategy for the future, the Government and officials in the Department are busy undermining and undoing any potential we have for success. Nothing in the Minister's statement gives me a reason to change my mind. It is disappointing that we all read much of what was in his statement in the newspapers at the weekend and earlier this week. However, I suppose that is par for the course.

With regard to the reference to the organisational reform of organisations that the Minister acknowledges are suffering from reform fatigue, does he envisage a devolution of power to ward level? I am referring to giving local clinicians and local managers the capacity and ability to recruit their own staff. Under the current system, it is very difficult to recruit staff because the power does not rest in the hands of the people who should be making the decision. Perhaps the Minister would elaborate on the continuation of the public and private mix and on whether, in future, he envisages allowing the clinicians and front-line staff to have the power to recruit their own staff. Without that and for as long as we maintain the current system we will continue to lose staff at a rate of knots and not recruit the staff to replace them.

Deputy Simon Harris: In response to Deputy Kelleher, I always thought the Department's and the Minister's views were supposed to align and that I was supposed to set the policy and the Department was supposed to implement it. I assure him my speech reflects that. Deputy Alan Kelly would remember how it is meant to work. Obviously, I have worked with the Department in developing my views on this since I took office but, in fairness, much of that builds on the thinking of the Department of Health over a number of years. We must be honest with each other. Often it has been the political system, and I blame myself and my party for this as much as I blame anybody else, that has failed to deliver on the long-term policy proposals that are generated by the system. In fact, many of the challenges that the HSE and others face, which I outlined in my speech, are challenges that have been imposed by the Houses of the Oireachtas, rather than by any unnamed bureaucrat or civil servant. These are my views, but I wish to get to a situation whereby the committee's views become the view of all parties in the House so that they will provide ten-year certainty in terms of the direction of travel. That has been lacking to date.

In terms of the employer, the Deputy asked a very important question. Two models could be considered, and I am interested in the committee's view on the way we should go. One could have stand-alone employments for the hospital and community health organisations whereby they would employ their own staff. The other model, and perhaps the more sensible way, is that one could have people employed as members of the overall health service and then assigned to the various group structures. Perhaps the question as to which one is preferable would have to be teased out.

With regard to geographical locations, I am always a little nervous about politicians drawing lines on maps as I am not sure that we are best placed to do that. I am not sure that we need the current number of hospital groups and I certainly do not believe we need the current number of CHOs. This is a small country. For a start, the CHOs and the hospital groups definitely need to align. That is my priority. What the geographical boundaries are is something on which I am happy to accept expert opinion and views and, indeed, local views through clinicians, hospitals, hospital groups and so forth.

The Deputy is right to highlight the difference between a clinical reason and a clinician's reason. There is a big difference. If hospital groups, or whatever we wish to call them, are to

work, that will involve a consultant or other doctors being assigned to more than one hospital. It will involve somebody living in a more remote or rural area having a consultant from one of the larger hospitals visiting their hospital to provide the appropriate services to be delivered in that hospital. The Deputy is right to differentiate.

We agree on the clinical voice in management. This has got lost somewhere along the line over the last decade. The Deputy and I meet the doctors as we go about our business. They are really frustrated. We hear them in the media. They basically feel that short of approaching the Deputy or me or going to the media, they cannot get their viewpoint across. That should be a cause for alarm for all of us. The clinical directorship was an idea to try to address that but I am not sure it has been fully empowered in the way I would like it to be. We should reflect on that. The three maternity hospitals in Dublin are all run by clinicians. I believe they are doing very well. It proves that clinicians can also lead the management team. That does not mean that every clinician must be a manager or every manager must be a clinician, but it is a viable option that should not be seen as the exception to the rule.

Regarding what the national agency will resemble, I would appreciate the Deputy's views on that. My view is that we do not wish to lose all that is good about the national agency. It is easy for people to come here and slag off the HSE, point fingers or be politically partisan about it. It achieved some good things in terms of national standards and programmes. Would the cancer control programme have been put in place without the HSE? Of course not. Those political and national decisions were taken. In my view, standards, care pathways, commissioning and budgeting rest with an agency. The daily operations and strategic planning for parts of this country should be devolved to a more local structure.

I agree with Deputy Naughton on the voice of the clinician and I have tried to address that. I understand the Deputy's concerns regarding the capacity review. Indeed, Deputy Kelleher and others have made those points to me as well. We do not want the HSE and the Department to simply decide on a given number of beds and then take the view that the box is ticked. We have tried to get the balance right with the international group and expert oversight. However, I believe it is important for the Department to have a sense of ownership of the document. In the past the Department has commissioned work only for it to become another report from another management agency. There is a question of balance and we will endeavour to get that right.

The comments on the realigning of the community health care organisations and hospital groups were dead right. We all visit hospitals. We have all witnessed the hospital manager expressing complete and utter frustration when a patient is ready to go home but the manager cannot get him or her home to the community. This is because the manager does not have in his possession the levers to try to get the patient into the community. The manager has to go to an entirely new management structure, the community health care organisation structure.

We talk about an integrated approach to health care but we have two silo approaches. For example, let us suppose Mrs. Murphy goes to hospital today. She goes in through the hospital group structure. Then let us suppose Mrs. Murphy needs to come back out today and she needs home care, an aid or appliance, nursing home care or access to the community and social care structure. It is not at one and I do not believe we can stand over it, certainly not as part of a ten-year plan.

I brought along to the meeting a picture that was sent to me when I became Minister for Health. It is of Bevan, the founder of the HSE. When he was setting it up, Bevan said that illness is neither-----

Deputy Louise O'Reilly: He never would have set up the HSE. He founded the NHS.

Deputy Simon Harris: Definitely not, God almighty. In any event, he said, "Illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community." No matter how many times certain people try to tell the people of this good country that I have a given view that I do not have, that comment represents my view. That is the view to which my party, the Government, the Opposition and all parties in the House have signed up. We want to get to a point of universal health care based on need. However, I have a duty to put it to any member of the committee who may become Minister for Health that he or she is going to have to find out what to do with the shortfall following any decision to the effect that private income would go from the hospitals.

I want to move towards a place where our citizens do not believe they need private health insurance. However, we are a long way from that. It would amount to blowing a €700 million hole in the health service budget were we to get rid of that private income.

People should not try to misrepresent my views at what is a cross-party committee. I am here in good faith. People should not try to misrepresent my views in a partisan sense. Deputy O'Reilly may be trying to create an ideological war. I believe in universal health care. Deputy O'Reilly can keep telling people that I do not, but that is my belief and that is what I want to deliver.

I also have a duty in this role to inform the committee of the complexities of arriving at that point. We have to address that in the report of the committee and in my consideration of how we work together. That is why it is right and proper, in fairness to the Chairman and the committee, to look at the ten-year horizon, because we cannot get from point A to point B immediately. It is a question of how we sequence arriving at that point. That is the challenge for all of us.

Reference was made to reform fatigue. The major reason people have reform fatigue is that they have seen a great deal of time spent on structural reform without many benefits for patients. It seems reform has been more about the structures and the systems rather than the patients. Therefore, any structural reform we undertake has to be stress-tested against the question of whether it will make a difference to patients. I genuinely believe that by removing layers in between the patients and the care they receive today, for example, the duplication of management structures between community health care organisations and hospital groups, we can improve things.

Reference was made to recruitment, delegated sanction, localising the process and empowering people. As committee members will be aware, we have localised the ability to recruit nurses through delegated sanction at director of nursing level in hospitals. This is based on a view that the INMO and SIPTU put to me. They made the point that it is all well and good for me or committee members or anyone else to say we are going to hire 1,200 new nurses this year, but when the staff go back to the hospitals they find great difficulty in doing that. We have delegated sanction to the director of nursing for 2017. It will be interesting to see how that works during the year. We have given a level of autonomy that they have not had before now.

Chairman: I thank the Minister. The next three speakers are Deputies Kelly, Barry and Brassil.

Deputy Alan Kelly: I thank the Minister for his comprehensive statement. This group is working to try to take the politics out of health and to deliver for years to come. The Minister is the sitting prince, for the want of a better phrase, and so we have to put questions to him as the person who holds the mantle at the moment, even though this will transcend his period in office.

This is a moving target. Things will change. Technology will change. Needs will change. Standards of living will change. Everything will change. What we put in place will have to be adaptable for the future. There is no such thing as best practice. There is practice and there are circumstances. It is a question of how we implement it. We have to be able to tailor it. My question is as much for Mr. Breslin as for the Minister. In any event, does the Minister believe that there is capacity in the Department of Health and the current structure of the HSE to do these things? Does the Minister believe there is the capacity, including the intellectual capacity, dare I say it, the will or the drive to do these things? It is not a personal thing; it is a real request.

We all know the HSE has to change. The Minister referred to dismantling and a leaner system, etc. I agree with the Minister's comments on alignment. However, I am concerned that any decisions that might be made may impact on what we are going to deliver. I appeal to the Minister to bear that in mind.

I agree with the Minister on a range of issues relating to primary care, capacity, etc. However, we are stuck for time so I will fire on with my questions. The Minister is currently in discussions with the general practitioners - as well as consultants - regarding contracts. The Minister referred to activity-based funding. That is an interesting thing and if we have more time, we will get into it. I have real concerns here. These are central issues. If any advancement in these areas is made that is contrary to what we come up with, then we could have a real issue. We need close alignment. We are aiming to head towards a single-tier universal health service based on need. Any potential commitments made to either of the groups I have referred to would certainly impact on that. Will the Minister bear that in mind?

Reference was made to the capital programme. We know what we have to do in terms of capacity. We know that we have to improve it. I agree with the Minister regarding alignment. There will be decisions on the capital plan but there is a cross-over in terms of the work of this committee. We have to be careful that decisions are not made from which we cannot row back.

Reference was made to case-based charging in the insurance area. That is an interesting concept and I would like to have more time to go through it. Will the Minister elaborate on his vision as the sitting prince? What does the Minister mean by that? How would it work? I am somewhat nervous in respect of going down this road about how it would actually work.

There are two areas where we cannot wait for this committee. I would be happy for the Minister to advance these areas. Ever since PPARS and every other information technology disaster that has arisen over the past 15 years, there has been no capital expenditure for eHealth. From a technology point of view, the situation for health care is a joke. I hope the Minister will advance that matter.

Chairman: I would appreciate it if the Deputy could wrap up now.

Deputy Alan Kelly: I am wrapping up. The same point also applies to integrated care.

The Minister referenced new politics. I do not believe in new politics. I am of the view that the concept is a joke, frankly. How would someone sitting in the Minister's position deal with the situation? We are going to put in place a plan for ten years. Yet, potentially, a report on the

Midland Regional Hospital, Portlaoise, could conclude that maternity services, accident and emergency services and paediatric services have to go. How will that come into place? I am not suggesting that it should. I am simply using it as an example. How would that come into place if there is a Minister who is representing that area sitting beside the Minister for Health at Cabinet, especially given the political times in which we live?

I am somewhat annoyed about this last matter. We read all the principal issues arising from the Minister's statement in the media before he came before the committee. That was disrespectful to the committee. Why did it happen? If it was simply a mistake, the Minister should say so and we will all move on. However, it is something the Minister should explain.

Deputy Mick Barry: I listened to and read the Minister's speech. He put an emphasis on the integration of services, the integration of hospital structures with community health care organisations and the need to move away from silo structures and the silo mentality. The Minister did not comment on the biggest silo of them all, however. He did not comment on the area that indicates the greatest need for integration. I refer to the fact that we have a health care system that is divided into at least four components, namely, fully owned and controlled public hospitals, the section 38 sector, the section 39 sector, and a growing private sector, including hospitals, nursing homes and home care agencies. The remit of this committee is to come up with a plan to deliver a universal, single-tier health system. It has been clear from the vast bulk of the witnesses we have had in and the vast bulk of the submissions that we need a stronger public health care system. I put it to the Minister that this objective is not compatible with a health care system in which only one section of four is fully owned and controlled by the State. The private sector has a vested interest in doing down the public sector. As many experts have said, for the private sector to succeed, the public sector must fail. Sections of the health service, including those under sections 38 and 39, and the private sector, could not survive for even a week in some cases without public funding and the backing they have from the taxpayer and public health service.

It is interesting that the Minister carries a photograph of Nye Bevan around with him at all times.

Deputy Simon Harris: Just today.

Deputy Mick Barry: I will resist the opportunity to make a jaundiced comment about that. It is a case not just of what we want to deliver for people but also of how we do it. Nye Bevan saw the instrument for doing this as a national health service free at the point of use, funded from general taxation of a progressive character and underpinned by legislation putting the responsibility on the Minister for Health. I put it to the Minister for comment that we are never going to deliver universal single-tier health insurance in this country without an Irish national health service of the type described that fully integrates under the banner of the public health system. This does involve measures such as nationalisation of the section 38, section 39 and private health care sectors.

Deputy John Brassil: I thank the Minister for coming in. He spoke about a slimmed-down version of the HSE. I would like to draw his attention to a document we all received a few weeks ago on the health executive structure. It refers to 24 different people, not including the staff of the seven hospital groups and nine community health care organisations. We were taken aback a little by the numbers. When we met Mr. Tony O'Brien early in our deliberations, we received a similar chart, which did not show half of this particular structure. I get the feeling that the HSE is moving in one direction. Perhaps it needs to be aware that this is happening.

The Minister's thoughts are very much in line with those of the committee. This matter needs to be tackled before it gets out of hand. There are 24 people in positions, with contracts signed and so on.

Another issue concerning contracts has arisen on a few occasions. The general practitioner contract is of significant importance in making future progress. There is an issue concerning the negotiation of the general practitioner contract. The Irish Medical Organisation is on board and the National Association of General Practitioners is not. I do not remember the name of the third general practitioner group.

Deputy Michael Harty: The Irish College of General Practitioners, ICGP.

Deputy John Brassil: I and other members of the committee believe it is very important to have the three groups on board. There will not be a meaningful contract otherwise. I hope the Minister can take that on board.

The Minister spoke about bringing the HSE under the Department and perhaps considering a director general over the whole structure. Would that bring politics more into the running of the HSE as opposed to less into it? We all have the ambition to try to take politics out of the future running of our health care service as much as possible such that it will be independent of whoever is in power and follow and stick to a plan.

The Minister referred to progress and to the initiative for the under-sixes. I do not believe that was progress; it was more of a retrograde step. Any future access has to be on the basis of need. Programmes should be extended to those in need. In this regard, reference was made to those with chronic illnesses, etc. These are the people whom we should be targeting. Clogging up the system with people who do not necessarily need the benefit in question is not the way to go forward.

Primary care was mentioned. Everybody in this room is very much on par in this regard. Investment in primary care, in addition to accountability and governance, is critical if we are to provide a good service in the future.

With regard to the hospital groups, the Minister spoke about more integration and carrying out more procedures in the smaller hospitals. It is a great idea but, in reality, unless there is somebody accountable for driving this and making it happen, it just will not happen. Hospitals will look after their own backyard. Unless there is somebody in charge of each hospital group, with, I suggest, a board of management to which they are answerable, we will not make progress in this regard. That is something we can put in place quickly.

Deputy Simon Harris: There is quite a lot there. With regard to Deputy Kelly's points on a couple of areas, I assure the Deputy I will not be moving ahead until we benefit from the committee's report. There are one or two exceptions, to which I will now speak. Any of the structural changes would require legislative change. We have a minority Government. I want to build political consensus and we need to do so. We will not be moving ahead with any of the structural changes, changes to the ABF or any other changes pending the publication of the committee's report.

Deputy Alan Kelly: The doctors' services.

Deputy Simon Harris: On the general practitioner contract, we have already had some engagement with this committee and heard members' initial views. We are at an early stage of

negotiations, which I expect will take the bulk of this year. We are very conscious of the need to align that final outcome. I am genuinely acutely aware of what is involved.

On the capital programme, the review will obviously take place later this year. I expect we will be able to benefit from the committee's report in time for that. That is my understanding.

Deputy Alan Kelly: I think the Minister should wait for this.

Deputy Simon Harris: This report is due next month so that would be it. On the question of whether the Department of Health and HSE have the capacity, I have a couple of points. Building up capacity will be key. There are many excellent people in the Department of Health and HSE but it is disconcerting to note that when one advertised in the past for certain jobs, including some senior roles at various levels within the health service, there was not the level of interest one would have liked there to be. One would hope that by paring back management structures, one would be able to have fewer managers, but perhaps remunerated according to a package that would attract international expertise. That is my genuine gut feeling on this.

There has been a lot of good work done in the Department of Health on building up expertise over recent years. Not that the Department would ever say it to me, I sense that there is nearly a desire in the Department at official level to get on with driving these measures. It needs the political leadership that I hope we can collectively bring to this on the publication of the report.

I acknowledge there are very strong views on eHealth. This is an area in which we are genuinely advancing already. I was talking to those concerned in the maternity part of the hospital in Kerry only last Tuesday. They are now producing eHealth records for all babies. Digital birth recording is now occurring in Kerry. That follows on from the initiative in Cork. It is being rolled out in the Rotunda next, I believe, or to Dublin in any case.

One hopes there will shortly be movement on the national children's hospital. I expect to see a significant eHealth element to the project also. We have a lot to do in this regard. There is a significant capital ask. I expect there will be a considerable amount of work on this in the committee's report.

Deputy Kelly probably used Portlaoise hospital as an example of a bigger issue.

Deputy Alan Kelly: It was only an example.

Deputy Simon Harris: I tried to refer to this in my speech. As politicians, making decisions, we will have to stand by clinical evidence. The benefit of trying to reach a political consensus is it strengthens the Minister of Health's hand. I regularly read in newspapers local calls for me to do this or that in the health service that contradict directly the clinical advice to me. I try to hold the line and follow clinical advice. It is important to differentiate between clinical advice and clinicians' views, which differ. Before any change happens in a hospital we have to make sure there is capacity in another hospital. I am not convinced there is spare capacity in many of our public hospitals.

I hope I understood the question about the private versus public charging mechanism. There is an odd incentive, which people have raised by way of parliamentary questions and at this committee, in terms of the private patient being more lucrative for hospital income than the public patient. One idea I have proposed is to try to align that rate of pay so that there is not a reverse incentive for a consultant to see more private patients.

In respect of the media, when I am asked at the weekend am I still planning to fulfil a programme for Government commitment to dismantle the HSE and what will I tell the committee next week, I am perfectly entitled to outline some of my views. When I was a member of the Committee of Public Accounts, PAC, however, I was always struck that it was not generally the witnesses who tended to leak the speeches. People might want to reflect on that today based on some of the commentary I have read and the level of detail.

Deputy Alan Kelly: That is why I asked the question.

Deputy Simon Harris: It certainly did not come from me.

Deputy Alan Kelly: That is all I wanted to know.

Deputy Simon Harris: I circulated the speech to members yesterday afternoon.

I agree with Deputy Barry on the need to create a stronger public health service. One reason health has been a partisan political issue for many years is it has suited many of us to exaggerate our differences on health. The overwhelming majority of people in this House, and I am one, want to see universal health care that can provide on the basis of need rather than ability to pay. The Deputy and I probably have different views on how we arrive at that point. I think we arrive at it by building the capacity in the public sector and convincing people that they can rely on the public service. It is possible to take out private health insurance in the UK but very few choose to do that. I do not see us outlawing private health insurance or private hospitals. As we improve the health service people will begin to move. The National Health Service, NHS, is far from perfect. We should also consider the headlines in the British press about its financial sustainability, recruitment and retention of professionals and see that it has similar problems. We should not hold up the NHS as a model but it is available as a founding principle for universal health care. I am wary of suggesting, as my party has done in the past, that we can go to any country and lift its health policy to use here. We need to have an Irish version of the system.

I agree with Deputy Brassil about governance. I will need a parliamentary majority to embark on a ten-year strategy and deliver universal health care. We should be embarking very quickly on a Bill to improve the governance structures of the current HSE while on that journey. If we can muster a majority and if the committee has views on what that structure might look like I would like to move ahead with it urgently. That would address some of the issues outlined in terms of making sure that my views, those of the committee and the Department can be properly conveyed to the HSE. The director general of the HSE has stated publicly there is a shared frustration at the current governance arrangements. That should be one of the first things we set about doing, as an interim measure.

The Deputy is dead right about the Department versus a national agency. The concern is that if it is subsumed back into the Department, it returns to the political realm. As for how much politics has been taken out of health care since the establishment of the HSE, in truth many of the issues I am asked about are operational matters. It is questionable how much has actually been removed. It is a legitimate point and that is why I have kept an open mind on it. I am very clear that the national element of the health service needs to be much slimmer and leaner. I am open to persuasion by this committee on its location as a stand-alone agency or within the Department.

Chairman: The committee wrote to the Minister to convey its views on issues that need to be covered in the GP contract. We also recommended that the Irish College of General Practi-

tioners, ICGP, would be involved to provide a strong policy base for the contract.

There is a lot of concern in the committee about the lack of independent oversight of the HSE and the fact that it does not have an independent board. It is very hard to see how that could be addressed without addressing the organisational structures at the same time. There are many views around the table on the other aspect of it.

Deputy Simon Harris: I am very open to the committee's views on this but I am concerned that the current governance situation should not be allowed continue. I am not pre-empting the report but if there are parts of it we can move on quickly alongside that I would be happy to do so. If there are parts that would take months I respectfully suggest, and we can engage further on this, that we consider a temporary measure to improve governance because I do not believe the current governance structures are in any way adequate for me to discharge the functions the House expects me to discharge.

Chairman: That does raise a lot of questions about decisions made before the Minister's time.

Deputy Michael Harty: There will be a recommendation on a decisive shift from hospital-based to community-based care, primary care and social care. Underpinning that shift will be a GP-led service in community and primary care and a new GP contract. This needs to be a radically new contract, as opposed to one that tinkers around the edges. Negotiating a new contract with only half the GPs is not good and will not yield a good outcome for the contract or the patient. We need the views of all GPs, not just a section of them. The Minister will repeat the errors of the past if he does not include all GPs in this contract negotiation. He needs to be courageous and decisive. In the context of the new health service we are proposing, it is very important to have a strong GP contract. It is a fundamental error not to include all GPs in that.

Chairman: The Deputy must declare an interest when talking about this matter.

Deputy Michael Harty: I am a member of the Irish Medical Organisation, the National Association of General Practitioners and the ICGP. I hold no candle in particular for any of those organisations as I have said in the past. I am considering the global situation in respect of the negotiations. It is very important to include everybody. I am thankful for the opportunity to say that. I ask the Minister to include all general practitioners in the negotiations. I ask him to address that issue today if he could.

Deputy Bernard J. Durkan: I welcome the Minister and thank him for his input and comments.

I have no ideological hang-up about the private and public health sectors. I am a strong supporter of the public health sector and hope that that is part and parcel of what we require in this country. The public and private sectors should complement each other rather than occupy each other's space. The input of the clinicians has been referred to as a cause of frustration. We have often talked about having an accountable, democratic forum where decisions are made and there is accountability. That is missing from the system that has been there for the past number of years, and that has to change. I believe the proper structure should comprise about four regional authorities which are directly accountable to the Department of Health and the Minister, who is in turn accountable to the Houses of the Oireachtas. That line of responsibility and accountability will remove many gripes taking place at present which cannot be removed or dealt with otherwise.

Health education has been referred to as a contributory element in the delivery of a good health service. I agree entirely with that. A much greater emphasis needs to be placed on health education, good health policies in schools with children and identification of the various health issues likely to emerge in the future long before it becomes necessary to refer them to a hospital.

I think we need something else as well. Living within our means with regard to the delivery of all services is important. At election time, we politicians tend to succumb to promising what we would like to deliver. We would all like to deliver everything but unfortunately we cannot afford to deliver everything. Therein lies the problem that emerges some time later when we take from what we already have in place in order to provide for something that we cannot afford without making the necessary provisions. It goes on all the time. We all contribute to that and that needs to stop.

The Minister referred to beds not being the entire answer. I am not 100% sure about that and I go back a long way on that. I heard this 20 years ago and 30 years ago throughout the health service. There was a shift away from beds in the UK, which said that no beds were required and to strip the number of beds down. We did that in this country, and yet every time a constituent comes to us, as politicians, inquiring as to when he or she is likely to get service, we ask why that person cannot get service and what the problem is. Has his or her consultant or GP gone on holidays, or is there a lack of beds? Lack of beds comes up again and again, and people say that their consultants cannot find beds. There has to be some reason that is the case, and unless we deal with that, we are wasting our time, because we are going to have a blockage in the system and it is going to hold up someone else.

Let us be careful about primary care. It costs money as well and the critical issue is the extent to which it is going to take money from other parts of the system. We need to put more money into it. There is no doubt about that. We need to have it along with the rest of the system and working in conjunction with it. As has been discussed by the committee, the linking up of the hospital system with regional authorities and dovetailing one to the other, from primary care to regional authorities, is an excellent idea.

I want to make a point on a matter I have heard a few times recently. The Committee of Public Accounts has no function relating to policy. It is specifically excluded from infringing on that area. We should never forget that. It deals with value for money and efficient spending of resources made available. It is not a policy-making body and has nothing to do with that.

We have the opportunity to reinvigorate the health services in line with the requirements of now and the future. We have previously been providing health services in line with what was sufficient ten or 15 years ago.

Deputy Kate O'Connell: I thank the Minister for coming in this morning and for his very comprehensive statement.

He mentioned the activity-based funding model. To reverse out of that, nobody is unaware that I fundamentally believe that one cannot quantify activity without geographical alignment of community health organisations and groups. Borders need to be found. I am putting on record for probably the 20th time that I do not see how it can work without that. I feel very strongly about clinicians in management roles. There cannot be an assumption that just because somebody has a medical background or is clinically trained that that person somehow has a deficit in management skills. Many GPs run practices where they manage a business as well as the clinical end. Pharmacists are able to manage a business along with our clinical roles, and to

declare my interests there, I am a community pharmacist. I cannot understand what the difference is once one moves into the acute hospital set-up.

Deputy Durkan mentioned good health policies in schools. To follow on from that, I firmly believe that giving medical cards to children under six was a very good move. I believe in that because I have seen throughout my career that just because somebody is well-off does not necessarily mean that that person brings his or her children to the doctor, and just because somebody is badly-off does not mean that that person does not bring his or her child to the doctor. I fundamentally believe that every child in this country is equal and should have equal access to everything, good health care being the first of those things. If we foster a generation that is brought up in the health service and is being monitored by GPs in the primary care setting, we then raise a healthy generation that is within the system, a bit like the digital babies in Cork. We start off with good data for a particular generation. I can understand how some people would argue that it should be need over age group, but there is an argument there for a phased approach to bringing people into the system, so we are looking at defined age groups within our population.

Moving to a primary care model requires money and also a change in mindset, for people to get it out of their head that they have to attend the accident and emergency department with a broken toe. We have to, through the work in this committee, in the Joint Committee on Health and the Minister's own work, convince the public that primary care is not a second-class place to go. They will get the optimum treatment. That is something that cannot be brought in overnight. It is something that we have to work to deliver to get public buy-in to it.

Chairman: We will extend the opportunity to speak to another Deputy and there are a couple of points I would like to make myself. That will be it, then, Minister. I call Deputy Josepha Madigan.

Deputy Josepha Madigan: I thank the Minister for coming in. I echo what Deputy O'Connell said about his statement.

One thing that came up more frequently in general terms, particularly with the TCD team, was about a "big bang" approach as distinct from a phased approach. I wonder what the Minister's views on that are. I think he hinted at what that may be but I would love some elaboration on that.

Chairman: I would like to raise a couple of points myself.

I note suggestions the Minister makes to address the provision of private care in public hospitals in the short term. Would he accept that the present system constitutes perverse incentives for hospitals where there are targets set for private income and that arrangement very much militates against public patients?

The Minister talks about a statutory basis for local structures within the health service in the proposal he has. I am keen to know what he has in mind for that. What kind of prop or structure would he be talking about?

On the issue of giving greater strength to a clinical voice in management, the Minister talked about the frustration for clinicians. I think it is fair to say that the frustration works both ways. One of the strong recommendations made to us as a committee, by Professor Tom Keane, was that hospital consultants would be made accountable at hospital level. I wonder if the Minister has a view on that. He actually suggested that it should be underpinned by legislation as is the

case in a number of other jurisdictions. I would welcome the Minister's views on those points.

Deputy Simon Harris: I thank the Chair. I will try to be quick as I know the committee is tight on time. I agree fully with Deputy Harty. One of the crucial terms of reference of the committee relates to the decisive shift to primary care. I have been very clear in my view that one cannot do that without a new GP contract. I add that GPs are not the only part of the very important shift to primary care. There are also advanced nurse practitioners, community nurses and many other specialties including pharmacy, dentistry and a range of therapists. However, a new GP contract is needed. The current contract is not fit for purpose because it originated 44 years ago and while it has been tinkered with in many ways, it has never been changed radically. A great deal has changed over more than four decades.

While Deputy Harty does not fully agree with me on this at all, I have tried to be more inclusive than any negotiations with GPs have ever been before. Even by his own declaration, the fact that Deputy Harty is a member of the NAGP and the IMO is interesting in and of itself. I wonder how many replications of similar GPs there are across the country. Certainly, I have the impression anecdotally that a lot of GPs are in both organisations. The reality of the situation is that there is a framework agreement between the IMO and my Department on the negotiation of GP contracts. I am respecting that framework agreement which it is important to do in this industrial relations environment. I believe in honouring agreements and that one says we must negotiate with the IMO. However, I have not just done that. I have brought the NAGP into the process for the first time ever. Deputy Harty will remember that it was excluded from the under-sixes contract. If one looks back at the record of the Houses, one sees that some responses to parliamentary questions suggested that the NAGP would never find itself sitting down with the Department of Health and the HSE. I am now finding a formal consultative role for it and I am willing to work with it on the formalisation of that role. Over time, let us see how that role develops and evolves.

While I agree that there needs to be a significant change in a new GP contract, it will not be a static document. I do not expect that we will negotiate now and that a Minister in 40-something years will have another conversation. This is an evolving process. I am due to meet with the NAGP shortly and look forward to having a fruitful engagement with its representatives on the issue. The ICGP is a slightly different body because it is the college. I note the Chair referenced that as well. I have had a good meeting with the ICGP and, while it does not negotiate for its members, I absolutely see a role for it in terms of feeding into the process. We will ensure that happens during the consultative process too.

Deputy Durkan is consistent on the issue of democratic accountability and he is right to be. We must ensure that whatever structure we put in place includes a way to provide democratic accountability. I will answer the Chair's question on my views in that regard in a second. I am not proposing in my contribution today that we go back to the health board structure and rip up all that is good about the national structures. There is a balance to be struck between devolved local decision-making on day-to-day operational issues and the absolute need for national structures and standards. One will not deliver a maternity strategy, a cancer control programme, integrated care, fair deal or eHealth without those sorts of things.

There is a clear need for more beds in Irish hospitals. I am not suggesting otherwise. What I suggest, however, is that it is not a panacea as I have seen in hospitals this winter, including in one where we opened a significant number of beds. It provided temporary respite in terms of trolley numbers and then they flared right back up again. We must recognise that a bed is not the same as something the members or I would sleep in at night. It is much more complex.

What type of bed is it? Is it an ICU bed, a rehab bed, a community bed or a general surgical bed? There are lots of different beds and where they are located within the health service, the community or hospitals is something we need to examine. There are also other ways to create capacity and if we make it about bed numbers only, we will let people off the hook in that regard. On predicted data discharge, it is inappropriate for a patient to go into a hospital today who is fit to go home on Saturday but who, because the work has not been done to ensure he or she goes home, ends up stuck there until Monday. He or she no more wants to be there than he or she needs to be there. Predicted data discharge provides capacity and hospital length of stay activity-based funding encourages more procedures to be done on a day-case basis also. This is somewhere we can evolve. The Deputy is dead right on demographics. We must plan not only for the present but for very different demographics, in particular in relation to chronic disease and older people.

Deputy O'Connell mentioned geographic alignment. I am one with the committee on this. Where those alignments happen and how one draws lines on a map is probably not a question for now, but I agree on geographic alignment.

On clinical leadership, I share the view that clinicians have a greater role to play in terms of management, but that is as part of a team. They cannot just be independent republics. They need to be answerable and accountable. Just because one is a doctor, it does not mean one cannot be a manager, but it is also the case that just because one is a doctor, it does not mean one will be a good manager. It should however be seen as one of the viable options for managing the heath service and parts of it rather than just something we do in the maternity services and which some perceive as being of a different era in terms of structure. It is a valid structure that should be looked at.

The way one ensures that primary care is not seen as secondary, if that is not ironic, is to put specialists out there. In the eyes of the public, primary care is probably seen as a matter of going to see a GP before going to a pharmacy to get medication and returning home. We are about to do work to put advanced nurse practitioners and specialist nurses in the community. Currently, one must go to a hospital to see them in relation to a number of chronic disease conditions. It is a step in that direction.

I agree that the under-six contract was good. If one is talking about primary care, one needs to extend universality. One has to start somewhere. Starting with our children makes sense. However, there are lessons to learn in terms of how it was rolled out as I have heard very clearly from GP organisations. We need to ensure that the capacity exists within general practice.

Deputy Josepha Madigan referred to a phased approach as opposed to the big-bang approach. We would all love to get to where we want to go by tomorrow. However, recent history sounds a number of alarms in that regard. Saying "I will abolish the HSE", as has been said in the past, turns out to be a great deal more complex than it sounds. The decision to put in place hospital groups proved to be a lot more complex than it sounded. Changing the model of funding ended up having to be abandoned. Setting up the HSE did not work out as anyone expected, although it was a well-intentioned idea. There is no way to do it other than by way of a phased process. This would be a committee for a six-month health vision rather than a ten-year health vision if that were not also the Dáil's general view.

On the Chair's questions, it is fair to say there is currently a perverse incentive. I tried to allude to that in my speech. One gets paid more for treating a private than a public patient. I am not sure how one could describe that other than as a perverse incentive. The 1999 White

Paper outlines the drawbacks of that but also outlines some potential benefits in terms of consultant retention and the like. These issues need to be teased out in a great deal of detail. There are measures one can take relatively quickly to remove the perverse incentive while having the broader, longer-term discussion.

There was a reference to how we wanted to place the hospital and community groups on a statutory footing. I would very much welcome the committee's views on this, but I envisage that this will be underpinned in legislation and that a board will be appointed. Obviously, we have hospital groups on an administrative basis with the idea of boards on an administrative basis, but it needs to be made statutory from a governance and proper accountability point of view. We need to consider in advance of drafting that legislation what we are devolving to groups and what we are retaining at the national level.

On the issue of clinicians, I fully agree with the Chair that clinicians are and should be seen as part of the solution. We cannot make people better without them. At the same time, however, they have to be accountable in terms of their own work practices. As I said in the speech, there are issues in relation to pay and tax that people raise when one talks about recruitment and retention but hand in hand with those discussions must go responsibilities, new functions and new roles. As such, I am interested in exploring Professor Keane's idea further.

Chairman: On the question of legislation for devolved organisations, does the Minister have it in mind that these would be public bodies?

Deputy Simon Harris: Absolutely. Is this hospital and community groups?

Chairman: Yes.

Deputy Simon Harris: Yes. Very much so.

Chairman: I thank the Minister. This has been a very worthwhile exchange of views and a productive session. We appreciate the Minister taking time to come to talk to us this morning.

The select committee adjourned at 10.50 a.m. *sine die.*