DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 27 Meán Fómhair 2017

Wednesday, 27 September 2017

The Joint Committee met at 9 a.m.

MEMBERS PRESENT:

Deputy Bernard J. Durkan,	Senator Colm Burke,
Deputy Billy Kelleher,	Senator John Dolan.
Deputy Alan Kelly,	
Deputy Margaret Murphy O'Mahony,	
Deputy Kate O'Connell,	
Deputy Louise O'Reilly,	

In attendance: Senator Kevin Humphreys.

DEPUTY MICHAEL HARTY IN THE CHAIR.

The joint committee met in private session until 9.15 a.m.

Estimates for Public Services 2017: Vote 38 - Department of Health

Chairman: The purpose of the meeting this morning is to engage with the Minister for Health, Deputy Simon Harris, to follow up on scrutiny of the Revised Estimate for 2017, which took place at the select committee on 2 March 2017 and prior to the budget of 2018, and to consider any Supplementary Estimates the Government may intend to propose. This engagement occurs in the context of the publication by the Minister for Public Expenditure and Reform of the 2017 mid-year expenditure report. On behalf of the committee, I welcome the Minister, Deputy Harris, and his officials, Mr. Greg Dempsey, Ms Fiona Prendergast and Mr. Martin Woods.

I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Any opening statement or submission provided to the committee may be published on the committee's website after the meeting.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable. Does the Minister wish to make an opening statement?

Minister for Health (Deputy Simon Harris): Yes.

Deputy Alan Kelly: Do we have copies of the statement or is it just a short contribution?

Deputy Simon Harris: It is relatively short but we have copies on the way. I am pleased to have an opportunity to provide the joint committee with an update on the mid-year review of my Department's Estimate for 2017. We have provided a comprehensive briefing to Deputies and Senators giving detail of the Vote position to the end of July, a summary of health service expenditure by service area to the end of June, performance information by divisional area to the end of June, and details of the HSE's performance and accountability framework.

Last year, the health Vote did not technically require a Supplementary budget to cover deficits. This was a direct result of the provision by the Government and Oireachtas of an additional €500 million in funding for the health Vote to improve the baseline funding of health, as well as of management efforts to remain within budget. The gross current budget for the health sector for 2017 is €14.152 billion, which is an increase of €457 million over the 2016 allocation. The health Vote, as members will appreciate, has increased significantly in the past three years, reflecting our commitment to try to provide a health service that seeks to improve the health and well-being of our people. The additional funding provided since 2015 has provided me with additional resources to try to invest in acute issues facing patients, such as winter initiatives,

in addition to meeting commitments in the programme for Government. However, there are still real fiscal challenges facing the health service and we must continue to focus on effective financial management to ensure that services are delivered in line with the national service plan and within budget.

Actual expenditure for the entire Vote for the first seven months of the year to the end of July is €8.29 billion, against a budget profile of €8.25 billion, suggesting an overspend in Vote terms of €40 million. The Department and non-HSE agency spending is below profile on current expenditure of €27 million. This largely relates to a timing issue on payments under the hepatitis C compensation tribunal and profiling issues relating to payments to directly funded agencies and is expected to reverse substantially by year end. There is a positive variance of €32 million on capital spending due to timing issues on the progress of a number of projects. Expenditure is expected to progress steadily as construction now begins, and the 2017 capital allocation will all be spent. Against these underspends the HSE subheads are €100 million over profile. There are a number of contributing factors to this overrun, including extra activity, costs relating to bringing forward the pay restoration under the Lansdowne Road agreement to April of this year, which were not profiled for and are as yet unfunded, and a higher level of settlements by the State Claims Agency than profiled. Overall, based on the position to the end of July and known financial challenges, we anticipate a level of overspend by the HSE linked to the 2017 pay agreements, the State Claims Agency settlements and expenditure in a number of service areas being over budget. The HSE, through its performance and evaluation framework, is undertaking action to reduce the level of this final potential overrun. My Department and the HSE are operating and planning on the basis that additional funding will not be available for any overspend in delivering the commitments set out in the national service plan, and I differentiate there from the other areas. However, we are discussing with the Department of Public Expenditure and Reform the situation regarding the funding requirement arising from decisions made subsequent to the national service plan, particularly central wage agreements, and any overrun in settlements by the State Claims Agency.

In terms of performance of the health services so far in 2017, it is clear that there are areas of good performance within our health service where activity is on target, while challenges clearly remain in other areas. The outpatient department waiting list action plan is focused on reducing the number of patients who would be waiting 15 months or more for outpatient appointments by the end of October 2017. Since the beginning of February to the week ending Friday, 2 June, nearly 42,000 patients had come off the waiting list under this plan. At the beginning of this month, almost 76,000 patients had come off the list. The inpatient and day case waiting list action plan is being delivered through a combination of normal hospital planned activity as well as additional funded activity utilising the funding provided in budget 2017. Between early February and the week ending 1 September, almost 21,000 patients had come off the list under this plan, and we will have seen in last month's published National Treatment Purchase Fund, NTPF, figures a significant decrease of more than 2,000 in the total number of people waiting for a hospital operation or hospital procedure in this country, showing the work of the NTPF beginning to kick in. While elective discharges in hospitals remain on target for 2017 and at the same level as 2016, day case discharges are up against the 2017 target and up on the same period last year. Cancer screening services metrics are showing positive performance improvements. For example, the national screening service for bowel cancer, BowelScreen, shows an increased client uptake, and the number of people completing the home test for bowel cancer is 19% ahead of expected activity, while the number of women having smear tests and mammograms through CervicalCheck and BreastCheck are also ahead of target. While many challenges remain throughout the health system, there are some positive stories to relay where

progress is being made on the ground through the hard work and dedication of many people working throughout our health services.

There are obviously service pressures being experienced, and these are seen particularly in our acute hospital sector and our disability services. In the case of the hospital sector, this is substantially reflected in non-pay categories and comprises increased complexity of activity, non-achievement of savings targets and a shortfall in income, while the pressures in disability services largely arise as a result of regulatory compliance and emergency placements. In the recently published mid-year expenditure report, the issue of health funding is highlighted as a major policy challenge, not just in this country but internationally. Despite a welcome increase over recent years, a financial challenge remains as we continue to deal in this country with a larger and older population, with more acute health and social care requirements. We also deal with increased demand for new and existing drugs - we have seen many examples this year whereby the Government made decisions regarding the provision of new drugs - and the rising cost of health technology. I wish to flag to this committee, as I have done on previous occasions, that the cost of payments under the State Claims Agency is continuing to rise, increasing the cost of health above that necessary to meet the health demands of a growing and ageing population, which remains a challenge. In fairness, this issue is outside the HSE's control; these decisions regarding how much compensation someone is paid or how much someone is paid through a claim are made in the courts.

Budget day is drawing closer and is of great interest not just to those in these Houses, but also to patients right across the country. My Department is in regular contact and engagement with the Department of Public Expenditure and Reform regarding the increased costs and the additional health priorities in 2018. Budget 2018 cannot just be about funding the health service as it currently is. It must be about funding new developments and new reforming measures. Many of the Members in this room sat on the Sláintecare committee and I am struck by their own recommendations in this regard. The discussions include the funding required to maintain the existing level of services, but also funding for priorities included in the programme for Government and funding to allow for the delivery of our capital programme in 2018. These discussions are taking place in the context of the fiscal constraints, which everyone is well aware of, and we are particularly conscious of our desire to reach a balanced budget in 2018.

With regard to funding for new developments, I assure the committee that the priority areas will reflect the commitments outlined in the programme for Government, many of which are also highlighted in the Sláintecare document. There are 132 commitments in the programme for Government in respect of health, and many of these have a financial cost. It will be necessary to prioritise and phase these initiatives carefully, conscious of the budgetary constraints within which we must operate. I would genuinely welcome the input and views of this committee as to where it feels the priority areas should lie, particularly in the space of what we call new developments.

For capital, notwithstanding the challenges arising from the impact of inflation, we will see major initiatives such as the national children's hospital, the new mental health hospital in Portrane and a substantial number of more modest and necessary projects proceed across the country. Many of these are already under way. In addition, the HSE has developed an ambitious eHealth programme which, through the Department and the Office of the Chief Information Officer in the HSE, has built significant momentum and support, and we need to build on that further.

While we have secured a significant increase in funding for the health services for this year,

I do not underestimate the challenges involved in the delivery of a safe, efficient health service for the people. We must maintain our focus on improving the way services are organised and delivered and on reducing costs in order to maximise the ability of the health service to respond to growing needs. In order for the Government to have the confidence to prioritise additional investment in our health services in 2018 and beyond, it is essential that those managing our health services and delivering the service demonstrate good practice by delivering the best possible health care within the limited resources that have been made available by Government each year. The Taoiseach has made the point, which is worth re-emphasising, that we pump an awful lot of taxpayers' resources into our health service. We need to grapple in these Houses and in Government with the question of how that money is spent and ensuring it is spent on the priorities we set in these Houses. I genuinely believe the work done by many Members on Sláintecare is extraordinarily helpful in this regard.

Chairman: I thank the Minister for his opening statement. I will now open the discussion to members of the committee and will take the questioners in groups of three. The first three members to indicate were Deputies Kelly, Murphy O'Mahony and Kelleher. I call Deputy Kelly.

Deputy Alan Kelly: I welcome the Minister. Not to be always negative, I will start with the positives. I compliment him on the way in which he dealt with the HPV vaccine and the manner in which he dealt with his Minister of State. We very much appreciate it. I know the Minister cannot comment on that, but we all need to stand up collectively in the political classes for what is right. I hope we will see results. That is the compliment out of the way - on to the negatives.

(Interruptions).

Deputy Alan Kelly: In fairness to the Minister, he has only brought three people with him today, not a whole army, so he has learned that lesson.

I have many questions. The horse has bolted. These are the results of the first six months so it is a historical document. It is something we are looking back on, and there is so much detail. There are some positives but there is also some seriously worrying stuff in here regarding targets and, collectively, between the whole lot of us here, we will probably get through quite a few of them. I will go through some priorities that I see and then ask some questions about future issues based on the information we have here.

Regarding the expenditure, we do not see anything about the children's hospital. If there is something about it here, it is hidden. Why is that? Where is it coming from? Where is the expenditure to date coming from?

I have some questions relating to the maternity strategy. It is a strategy that we are all in favour of and I am hugely supportive of it. I think it is an excellent document. It is one of the best documents relating to the health area ever written in this country. Again, however, we do not see where the supposed expenditure is and the key issue for me is that we are two years into the strategy but it is just not happening. The soft stuff is happening and that is good, but anything that needs money is not happening. I ask the Minister to address that point.

In terms of capital projects in general, what projects have been delayed? Given the figures that have been produced here, it seems that there are capital projects that have been delayed. I ask the Minister to outline where those projects are, what they are and why they are delayed.

We can see from the figures that there is an overspend in the acute area while there is an underspend in primary care. We all, in both the Sláintecare process involving the Oireachtas Committee on the Future of Healthcare as well as in this committee, agree on one thing, namely, that primary care spending needs to go on an upward trajectory. We need to see a re-balancing of the percentage spent on primary care *vis-à-vis* acute care. It is still going in the wrong direction and is not being arrested. We are talking here about expenditure to mid-year. We have not even seen the winter. If we are €104 million over in acute care already, what are we going to be over by the end of the year? Last year, the chief executive of the HSE, Mr. Tony O'Brien, wrote to all of the regional CEOs - he did not write to them himself but very controversial letters relating to performance were sent. I have some sympathy for those CEOs in terms of how expenditure is being managed because, in some cases, they do not have full control over the levers. Obviously there are demand-led services and a range of issues in terms of commitments given to them in the context of the capital plan that did not happen and so forth. They still have legacy issues which result in expenditure that they cannot control. If commitments are made in the community and primary care areas, for example, that are not honoured then expenditure in the acute hospital system is going to explode. What will be the result of that?

In terms of primary care centres, the difficulties have been going on for years. We are way behind schedule as regards the roll out of new centres and there are lots of complications. I have asked questions of the HSE regarding certain primary care centres and have not even received a response. I will give the Minister a note on that. I have asked the director general about one primary care project in particular on two or three occasions but I still have not received a response. He delegated to his assistant, who did not came back to me. How much of the spending on primary care centres is actually on new centres?

In terms of the fair deal scheme, why is the expenditure so low? It is way lower than expected. There must be some evidence to explain why that is happening. Given where we are going as a country, demographically, is the Minister surprised by this? Is it related to other macro-economic factors? Why is it happening?

When it comes to the primary care setting, the figures indicate that approximately 30% fewer patients are being seen by nurses in the primary care setting. We want more people to end up in primary care settings and we want more primary care centres. We also need to ensure that those who have issues that can be dealt with by nurses are being seen by them. However, we are seeing an actual reversal of this. Why is that happening?

Every single Member of both Houses of the Oireachtas has had issues with medical cards and the processing of same. We now have a situation where the processing is under target by 64% and we are being told that there are staffing issues. Seriously, what is going on here? That just does not stand up to scrutiny. This is a real issue for people, on a human level.

The Minister knows that I am quite passionate about the area of home help. I firmly believe in home help. I believe we need to develop a new attitude towards home help. I understand the issues with regard to getting staff and training people for this area into the future is critical. Keeping people in their homes means less expenditure on nursing homes and on acute services. The domino effect here is a matter of common sense. It is a win for patients, the public and families, as well as for the taxpayer. The targets for home help hours are not being met. This is an issue that I deal with all of the time, on a day-to-day basis. Granted, there are issues related to finding staff. What is being done in that regard? However, there are bigger issues, including the number of people who are approved for large home care packages but who cannot get their quantum of hours, or anywhere near it. If an elderly couple is granted 20 hours but only gets

eight or ten hours, they are nearly happy. That is completely unacceptable.

We have a whole profile here relating to acute hospital targets. Frankly, we could go through this every three months on a continuous basis but at this stage it must be said that some of the targets are just not realistic. They are being missed left, right and centre and in some instances, by some margin. If one looks at prostate cancer under various metrics, for example, one must ask if we need to re-evaluate the targets. I have an issue with regard to the targets.

The data on the ambulance service is jumping out at me. There are numerous issues relating to the ambulance service and we have discussed them previously. I have repeatedly asked the Minister about the roll out of intermediate vehicles and the recruitment of staff for same. We have situations where we have different model hospitals that are integrated into a network but which are dependent on an ambulance system that simply cannot function to the level required, in the context of the network of hospitals and how they operate. In the mid-west, for example, there are people who should be in Ennis or Nenagh but who cannot get transported there on time. At the weekends, certain hospitals end up packed with people who should be out in the model 2 hospitals in Nenagh or Ennis. They cannot get transport, even though there are beds available in those locations. The Chairman, Dr. Harty, knows all about this issue. It has been going on for years. It is basic stuff. The people do not even want to be in Limerick; they would rather be closer to home and there is no need for them to be there.

My final few questions relate to risks and future funding. When will the new winter initiative be announced? How is the Minister going to profile it? Where is he going to find the money for it, given that we are already well over budget?

There is a very interesting court case going on in Ennis at the moment relating to St. Joseph's nursing home. There are two State bodies involved, the HSE and HIQA. They are basically going at one another in relation to the accreditation of the nursing home. I have serious concerns about how this is being conducted. I am concerned about the role of HIQA and about how information about the home has been put into the public arena. In fairness, the HSE is not being treated well here but that is not the real issue. The real issue is that if this case goes in a certain direction, we could end up with a domino effect across nursing homes in this country which will result in serious damage to public confidence and increased expenditure. Is this being profiled for? This is a case that must be settled by the second week in December. What is the thinking in relation to it?

As the Minister is aware, we speak a good deal in this committee about orphan drugs. In fairness to my colleagues, we have spoken about the nine drugs we believe need to be brought through the process and made available to the patients who badly need them. I refer to Entresto and eight others. A very embarrassing situation arose regarding the accreditation of those drugs passing forwards and backwards between the Department to the Health Service Executive, HSE. It was embarrassing for all of us, including the Minister. I happened to be on the "Today with Sean O'Rourke" show talking about that when a major statement came in stating that in July, the HSE would fund all nine drugs. It is nearly October and we have not heard an iota about that since. When will the funding be in place? When will the patients be able to avail of them, as in this year, because the statement clearly indicated they would be available this year? Also, where will the funding come from?

Deputy Margaret Murphy O'Mahony: I welcome the Minister and his officials. I would like to officially congratulate him on his recent wedding. I have no doubt there were many heartbroken young women around the country, and maybe some who are not so young. That

may be pushing it, but it sounds good.

I thank the Minister for his presentation. I have a few questions, although Deputy Kelly covered some of the questions I was going to ask. I find it difficult to understand the reason the number of home help hours and those receiving home care packages is down when my office is inundated every day with people requesting a home help service. That does not add up for me. The Minister might comment on that.

My baby is the issue of disability. Every Department would like a bigger spend in the area of disability but I highlight for the Minister the huge waiting lists, not only for a diagnosis but for follow-on treatment. That is particularly important for young people with early intervention being so important.

I would like the Minister to comment on what he is spending on advice and prevention in terms of trying to encourage people to eat healthier and exercise. That would result in less of a spend in time to come because it might prevent people developing diabetes and other diseases.

On the winter initiative, last year was a bit of a learning curve but has the Minister other plans in place to make it work better this year? In essence, it was not a huge success last year.

Deputy Billy Kelleher: I welcome the Minister and his officials and thank him for the presentation. While it is a historical document there are things we can glean from it that may assist us in the months and years ahead in terms of learning from the challenges we face and even the mistakes made from time to time.

A few issues arise, some of which were brought to my attention in advance of this document. The child and adolescent mental health services across the country are under huge pressure and stress from the point of view of recruitment and the lack of psychologists and psychiatrists in the service. That a huge number of children are still being admitted to the mental health services, not into adolescent units but into adult wards, which has been condemned and deemed wholly unacceptable from a clinical and a human rights point of view, is an issue of grave concern.

Regarding the child and adolescent mental health services in Cork, from what I can gather, and I would like the Minister to check this out and address it in a meaningful way, we do not have a permanent clinical governance structure in place in terms of personnel; we have the structure but not the personnel. We do not have a clinical nursing director. The assistant nursing director, which is a level 2 position, is acting in a level 3 position under that. We have no permanent clinical governance structure in the child and adolescent mental health services in the Cork area. That issue was brought to my attention recently by union representatives who are very concerned about it. While I do not expect the Minister to comment now I would like him to revert to me on it. Otherwise, I will have to raise it in the Dáil. It is an issue of huge concern across the country.

We always talk about the inability to recruit psychologists and psychiatrists and that being the main problem, but when I look at the HSE recruitment levels, and I put down some parliamentary questions on that previously, I see that there does not seem to be a ceiling or block in terms of recruitment on the administrative side. That figure has increased from 1,075 last year to 1,159 this year. The Minister will say that the HSE is expanding and so on but we seem to be incapable of recruiting clinicians across all specialties while at the same time the HSE is recruiting up to three managers a week. We would want to reprioritise, while resources are scarce, and

ensure that efforts are made to recruit those who will work on the front line and try to make the management system lean as opposed to bloated. I urge the Minister to look at that.

Reference was made to two issues I wanted to raise. On the children's hospital, the legislation to amalgamate the three hospitals is coming forward. Where is the template for the construction of the hospital both in terms of the timeframe but also the funding to underpin it? Will a multi-annual budget be in place in the capital spend for the hospital or will it be very much on an annualised stop-start basis? The Minister might give us clarity in terms of what he envisages with regard to that issue. It is a huge undertaking. Concerns were expressed previously about construction inflation and the cost of the hospital itself but does the Minister anticipate there being a multi-annualised, ring-fenced budget in place so that it can be built in a planned phase as opposed to depending on resources being made available more or less out of current expenditure?

Home help hours were referred to by Deputy Margaret Murphy O'Mahony. Sometimes I think we live in a parallel universe in terms of what we read in official reports and what we experience in our constituency offices. Not a day or a week goes by that we are not hounding people trying to get a half hour of home help care here and there. We now have a deficit of 5.4% in the number of people in receipt of home help hours; it has gone from 49,000 down to 46,339. That is extraordinary when I, along with every other Deputy in this House, are consistently looking for home help hours.

That leads me to the issue of primary care. Admittedly, the budget is down by only a small amount - €5 million or €6 million - in the overall spend of approximately €1 billion but is the HSE serious about trying to ensure we bolster primary care services and lighten the pressure on our acute hospital system? There is an overspend in our acute hospital system of approximately €107 million and there is an underspend in the primary care budget of €7 million. Everybody tells us, including the discussions on finalising the Sláinte Care report, from speaking to people at the coalface, primary care strategies, and all political parties are in agreement, that if we front-load spending in primary care and health and well-being, we should at least reduce the pressures on our emergency and acute hospital system over a period of time. However, we seem to be incapable of planning our primary care system in a meaningful manner.

Reference has been made to the roll out of our primary care centres, which is haphazard. While the building may be there, there is very little activity within. The entire primary care system seems to be an afterthought when it comes to funding. I can understand that the hospitals suck resources. If we are to be serious, however, we must ensure that primary care investment is at least on profile and that we are spending as anticipated, as opposed to spending less and transferring that to the acute hospital system.

The maternity strategy has been mentioned and I will await the reply on that.

This morning, Patricia Flynn, spoke on the "Morning Ireland" programme. Scoliosis is an issue that I and many other Deputies have raised in the Dáil. Many people are campaigning in respect of it. Scoliosis was also raised on Leaders' Questions yesterday. I realise that the Minister has as much interest in this as every other Deputy and that he feels for people whose procedures are delayed. However, Ian Flynn was born with spina bifida and later developed scoliosis. He has been waiting over a year for surgery. Patricia Flynn spoke on "Morning Ireland" this morning so I am not divulging anything that is not already public knowledge. Ian is twisting in his wheelchair. His upper spinal curvature is now 68% whereas it had been 40% last year, while his lower spinal curvature is 78% having been 62% last year. His scoliosis has

progressed enormously in 12 months. Initially, the family was told that his surgery would take place in the summer or the early autumn. His mother has made contact with his surgeons on numerous occasions and been told that they are aware of Ian's condition but that they have no date yet for the surgery.

I accept that the Minister has spoken about this in the Dáil in reply to Deputies, including myself, and explained that the theatre in Crumlin hospital, where there had been difficulties with recruitment, has been opened. However, surely it is not beyond the ability of the State to prioritise surgeries in a way whereby we do not have to listen to mothers of children with scoliosis almost begging on national fora for their children to be dealt with in a meaningful, humane manner? I urge the Minister to do everything in his power in this regard. He has explained that the National Treatment Purchase Fund is in place and that this is increasing the number of surgical interventions, but the waiting lists are still increasing. More people are on the waiting list now than there were last year. If the Minister can do one thing in the next few weeks, he should refocus and prioritise the resource allocation for scoliosis. If he has to front-load for the National Treatment Purchase Fund, he should do so, even if it requires bringing in paediatric and orthopaedic surgeons from outside the State rather than taking patients out of the State. That should be done because this issue is a blight on the health services. It is certainly a blight on the future of many children. I urge the Minister to do that if he can. I accept that he is as compassionate as the next person on this but it is no longer about compassion. It is about action.

Chairman: I invite the Minister and his officials to address those questions.

Deputy Simon Harris: I thank the Deputies for raising a wide range of issues. I will begin by thanking Deputy Kelly and, indeed, the members of this committee for the leadership they have shown on the HPV vaccine. It is important that we speak with one voice in respect of this matter. Adults in this country are dying needlessly of cervical cancer. Every year, approximately 300 women will contract cervical cancer and, sadly, almost 100 of them will die. We have a vaccine that can prevent that cancer and there is no room for any ambiguity or confusion on this issue. Deputy Kelly has publicly expressed an interest in extending this vaccination to boys and I acknowledge his interest in that. HIQA is currently undertaking a health technology assessment in that regard and I will not be found wanting in acting upon it. We can keep in contact about that.

The revenue budget for the children's hospital is included as part of the Children's hospital group budget. I can get the Deputy a detailed note on that under the acute heading in the document. Obviously, it is a substantial part of our capital plan. Deputy Kelleher also sought information on this. It is a multi-annual capital plan. The Government took a decision - in advance of the ten-year capital plan and the announcement of the capital envelopes for the next number of years on budget day - to prioritise this project. That is why it has commenced. There is a substantial taxpayer commitment to this in the context of multi-annual funding. I will be happy to provide the committee with a detailed note on how that will be profiled over the next number of years.

I will launch the implementation plan for the maternity strategy in the next couple of weeks . Deputy Kelly is correct that it is a superb document, but a document is only as good as its implementation. I believe it was Eisenhower who said that the plan is nothing and that planning is everything. We have a very good plan so we must put it into action. Work is already under way in that regard. We increased the budget for maternity services this year with the provision of an additional €6.8 million. That was up from an additional €3 million provided in 2016 to

allow the strategy to progress. However, we will publish a detailed implementation plan in the coming weeks.

With regard to capital projects, the national children's hospital started later than had been wished so that largely accounts for the underspend in capital. However, it is expected that it will have been rectified within this year. We will spend all our capital allocation this year.

On the broader issue of primary care-----

Deputy Alan Kelly: There are no projects behind schedule.

Deputy Simon Harris: The national children's hospital was due to start earlier-----

Deputy Alan Kelly: Aside from that.

Deputy Simon Harris: Other than that, the projects are proceeding in accordance with the plan and we will spend all our capital funding this year.

The Deputies highlighted the importance of primary care. When the former Deputy Rory O'Hanlon was Minister for Health at the end of the 1980s, he spoke about the importance of making a decisive shift to primary care. Every Minister for Health since then has done his or her bit to help with that, but we must get serious about it now. I do not believe we can make the substantial progress that is needed without the new GP contract. I expect to have significant progress on that by the end of this year. Hopefully, this will enable us, subject to normal budgetary constraints, to roll out a number of developments in 2018, 2019 and beyond that would see services which are currently provided in the acute hospital setting being provided in a primary care setting. There is no disputing the fact of the underspend, although Deputy Kelleher acknowledged that it is very small as a percentage of the primary care budget. There have been some delays, particularly in respect of the recruitment of staff. We are all aware of that from our constituency work as well as our work in the Dáil. We are hearing that is improving and we are expecting that the primary care budget will be spent in full this year.

With regard to the primary care centres and the lack of response afforded to Deputy Kelly, that is not appropriate. Every Member of the House should get official responses from the HSE. I will follow up on that.

As regards the fair deal-----

Deputy Alan Kelly: On the capital side, I asked the Minister about the primary care centres. How much of the spend on primary care was on new primary care centres? If the Minister does not have that information perhaps he could forward it to the committee.

Deputy Simon Harris: I will have to get that for the Deputy. I do not have it in my folder.

On the fair deal scheme, we are in a much better situation with that than we were in past years, when the scheme was underfunded. There were extraordinarily long waiting periods. When the Deputy's party was in government with ourselves - happy days - the waiting times relating to the fair deal scheme reduced to four weeks or, in some cases, less. We have maintained that. Fair deal funding is being provided now in four weeks or less. We expect that most of that budget will be consumed in the current year but, so far, there has been a lower volume than we had expected. I prefer to err on the side of caution in terms of over-providing in this area because we are aware of the difficulties we can encounter when there are waiting periods of ten to 12 weeks. At one time they were up to 16 weeks.

Deputy Alan Kelly: I wonder if there are greater economic reasons for that or if there are other external factors.

Deputy Simon Harris: We are all aware of people in the community telling us that they find the fair deal scheme does not work for them, be it a farmer, small business owner or people who might wish to rent or sell their house and wish to be able to keep a greater proportion of the proceeds. My colleague, the Minister of State, Deputy Jim Daly, is reviewing a number of those issues. That might expand the pool of people who might find the fair deal scheme more appealing than is the case currently.

On medical cards, the Deputy is correct that there had been a staffing problem. I am assured by the PCRS section that this is now resolved and that there will be a significant improvement in the turnaround times in the next published figures, which are due shortly.

The Deputies referred to home help. I have a couple of comments on that. In certain CHO areas there is a capacity issue regarding the availability of home care staff. That will not be a surprise to anybody. In some parts of the country we do not have that problem while in others there is a very significant challenge in that regard. In such cases, the HSE and local CHOs try to utilise the home care package scheme to enable a person to remain at home or return home. While many have quoted figures pertaining to home help hours, those needs to be considered in the context of the home care package figures. The number of intensive home care packages is 22.1% ahead of target and the number of general or more regular home care packages is 9.9% ahead of target. The statistics tally with anecdotal evidence of CHOs utilising home care packages more and more when home help hours are not available. Many in attendance, such as Deputy Kelly, have spoken in favour of a statutory home care scheme. Deputies Kelleher and Murphy O'Mahony's party colleague put forward a Bill in relation to a version of the fair deal scheme for home care. Everybody was inspired to do more on that issue by Brendan Courtney's very telling documentary that highlighted the situation faced by many families. The Government is committed to introducing a statutory home care scheme. All members want people to be able to stay at home in their community and grow old with dignity in the place he or she is from but the nursing home support scheme or fair deal scheme is the only statutory scheme. The home help scheme does not exist in statute but, rather, it is *ad hoc* and not consistent in different parts of the country. As members know, it is not easy to make it a statutory scheme. Consultation is due to close in early October and we will be able to begin to outline the scheme in 2018.

Deputy Kelly has identified a fair point on targets. They need to be re-evaluated and that is being done in the context of the preparation of the national service plan and budget 2018. There is a careful line to be drawn between not removing the responsibility to reach targets from hospital managers and stress testing the targets to ensure they are realistic. Managers make a difference and good management makes a big difference. Figures published by the Irish Nurses and Midwives Organisation, INMO, rather than the HSE for patients on hospital trolleys over the period January to July of this year show that Beaumont Hospital had its lowest number of people on trolleys since the counting of trolleys began in 2006, as did Connolly, Cavan Monaghan and Mayo hospitals while St. Vincent's University Hospital, one of the large hospitals in Dublin, has its second lowest number since 2006. Were Deputy Kelly to pre-empt what I might say next as being that one can also identify record highs in those figures, he would be correct. However, there are capacity and staffing issues in all hospitals in the State, yet some are making far more significant progress than others. I do not accept the idea I sometimes hear from certain elements that all hospital managers are the same and everybody is doing an excel-

lent job. It is clear that some are doing a far better job than others.

Deputy Alan Kelly: I have no problem with that but it is not comparing apples with apples and oranges with oranges because if one considers the mid-west area, a brand new three and a half time capacity emergency department was opened but the volume of people going to it went up by 40%. The real issue is how can one measure apples with apples and oranges with oranges if the Minister is comparing Beaumont or Connolly hospital with Limerick hospital-----

Deputy Simon Harris: I did not do so.

Deputy Alan Kelly: ----based on those accurate figures, considering the infrastructure------

Deputy Simon Harris: I did not do so.

Deputy Alan Kelly: -----into the network of hospitals and in the community is a disaster?

Deputy Simon Harris: There are particular challenges in the mid-west and I will not take away from that. Equally, the CEO of Beaumont Hospital could also point to particular challenges such as those involving older people. Every public hospital in the country is facing serious challenges for a variety of reasons. Some need more beds while others have poor infrastructure or difficulty attracting staff. They all experience demographic pressure. The Deputy has said it is not comparing apples with apples but that is how all in attendance and the media will report the figures as it suits. Several hospitals that, like other hospitals, face significant challenges are, according to the nursing union's figures, recording their lowest number of people on trolleys. I am not suggesting anyone should get excited or delighted about that because the number of patients on trolleys is extraordinarily and unacceptably high but there has been a huge effort in some hospitals, sometimes with extra resources and sometimes not, and very good results have been achieved.

Deputy Alan Kelly: I accept that but I do not agree with the MInister's premise. The hospitals and networks in the areas of which he spoke need to be profiled differently.

Deputy Simon Harris: That is true.

Deputy Alan Kelly: They cannot be compared to one another on the basis of bottom-line statistics or even measurability based on information on a spreadsheet relating to increases or decreases in the number of patients on trolleys. It is a joined-up issue that is not working across the networks. I asked the Minister about ambulance services. As the Chairman knows, there are record numbers of patients on trolleys in hospitals such as that in Limerick in the mid-west. People cannot be taken out of the hospital. That is not a failure of those working there. There is a broader issue in relation to transport. Unless those issues are addressed, the patients have nowhere to go.

Deputy Simon Harris: I do not dispute that. Deputy Kelly's logic is that different parts of the country are different. There are probably similar issues in some Dublin hospitals-----

Deputy Alan Kelly: They are not similar. That is impossible because the geographical distance between hospitals is completely different.

Deputy Simon Harris: Perhaps the Deputy will allow me to finish. Some Dublin and rural hospitals are performing far better than others. I have never heard anybody pointing out where good practices are leading to improvements in the number of patients on trolleys and patient experiences. Perhaps I do not do so enough. There is not sufficient consideration within the

health service of why Beaumont, Cavan or Mayo hospitals now have very low waiting lists and numbers of patients on trolleys compared to previous figures and what can be learned from that. Every hospital manager can give me a wish list what he or she wants to happen in his or her hospital-----

Deputy Alan Kelly: I agree with doing that but the opposite also has to be done in terms of who will support people to get rid of blockages in relation to throughput and pathways for patients entering hospital.

Deputy Simon Harris: If one puts in those extra resources-----

Deputy Alan Kelly: That is the Minister's job.

Deputy Simon Harris: It is my job and I am determined to do it and am doing it. If those resources are put in place, who will then take responsibility for delivering an improvement for patients? Over many years and Governments additional resources have been put in place that are not linked with additional-----

Deputy Alan Kelly: I accept that it is not all about resources.

Deputy Simon Harris: We got there in the end.

Deputy Alan Kelly: However, some people are not being helpful.

Deputy Simon Harris: I acknowledge there are particular issues in the mid-west area and I will meet the Limerick hospital group tomorrow to discuss some of those issues.

Deputy Kelly raises the issue of ambulances with me on a regular basis. Additional funding of €3.6 million has been made available to the national ambulance service, NAS, this year. It is responsible for 1,700 staff, 490 vehicles and a total budget of €155 million. Inter-hospital transfers were to be prioritised in its budget. The Deputy is correct that there are patients in Limerick hospital at weekends who could be elsewhere.

Deputy Alan Kelly: Did the NAS prioritise inter-hospital transfers?

Deputy Simon Harris: There has been an increase and I will provide a specific note to the Deputy in relation to how the additional €3.6 million has been spent.

Something different is being tried in terms of this year's winter initiative and it is time that is done. A bottom-up approach is being taken. There have been too many winter initiatives, possibly including what I implemented last year, where Dublin has been central to decisions on what will be done for the winter and all other areas had to get on board with that and the message was passed down to local hospitals. As the Deputy eloquently pointed out, there are different challenges in different hospitals so this year every hospital in the hospital group structure has been asked what would be of most help to them if additional resources were to be made available. Interestingly, very different replies were received. Some requested extra discharge co-ordinators because the hospitals do not have the capacity to discharge enough patients, in particular over weekends. Others have raised issues such as longer opening hours for in-hospital diagnostic services. One requested an additional porter to help people get to and from diagnostic services more quickly in order to facilitate a quicker patient turnaround. The issues of additional beds and home care packages are being considered. We will be unveiling the measures shortly. Some of the winter initiative funding from last year has gone into the HSE budget for this year. I am also in discussion with the Minister for Public Expenditure and

Reform, Deputy Donohoe, on several matters in the context of the budget.

I am constrained in what I can say in relation to the issue in Ennis.

Deputy Alan Kelly: I did not ask the Minister to talk about.it. I asked him to talk about the consequences thereof. Have contingency plans been prepared?

Deputy Simon Harris: I need to be very careful not to pre-empt the outcome there-----

Deputy Alan Kelly: I agree.

Deputy Simon Harris: -----because there is a legal situation. However, I am happy to keep in touch with the Deputy on the matter. I am very well aware of it.

Deputy Alan Kelly: This is a groundbreaking case and I am glad the HSE is taking it.

Deputy Simon Harris: I am aware of it and of the potentially significant consequences as well.

I thank the Deputy for raising the issue of orphan drugs, because we need to have a serious conversation on this. On Topical Issue debates, I am constantly asked if I am going to make this or that drug available. This is despite the fact that the Dáil passed legislation in 2013 which gave all control in this area to the HSE. If people feel that the current system is broken, I would like to hear their views on what should replace it. I think it is broken too. Coming up with a better model is the conundrum.

On those specific nine drugs, the HSE informed my Department in July that it wished to make those drugs available to patients. Only the HSE can make the decision but it is supposed to inform and consult the Department if it is concerned that it cannot provide the necessary funding. Agreement was reached that the funding would be made available from within the PCRS budget, which has been showing a surplus this year. The cost for 2017 is quite minimal for these nine drugs. That decision was made and the funding is in place. I want to be crystal clear on that. The drugs are expected to be available to patients from 1 November. I understand that the target in the intervening period is to deal with matters such as prescription pathways, normal contractual arrangements, etc.

Deputy Alan Kelly: I presume the Minister knew that this question would be asked in some shape or form. I agree that the system is broken. What happened in the context of provision and of arriving at this point was a joke; it was farcical and embarrassing. It was embarrassing for the Minister and for us, as politicians. The process by means of which these drugs are accredited was also embarrassing. I refer to the need to go from Billy to Jack and then back to the Department, which was just laughable. The letters that were written in respect of this issue are laughable.

I agree with the Minister that the issue must be addressed. We can work with him on it. Unfortunately, or fortunately, the process to which I refer is in place and will be until we, collectively, take action to change it. The issue is that a commitment was given in July, basically on foot of media and political pressure. Everyone knows that these drugs are a necessity, and, based on the cost, they have already been approved. One of the drugs is absolutely essential and cost-neutral in nature. As far as I am concerned, the announcement in July was a false announcement. Today is the first time that I have heard the date of 1 November mentioned. The announcement was made, to great fanfare, in July. I was discussing this issue live on "Today

with Sean O'Rourke" when the statement announcing that this matter was going to be dealt with was issued. That has happened. What happened in the remaining weeks of July and in August, September and October? The announcement was made but, from a profiling point of view, there was no intention of providing funding until the last month or two of the year.

Deputy Simon Harris: I agree that the entire process was extraordinarily unedifying. This kind of back-and-forth spat is not the way that things should happen. I do not agree that there has been a delay in terms of the provision of funding between July and 1 November next, the date on which these drugs will be available. I can reassure the Deputy that this is not the cause of the delay and that there is adequate funding this year, from the relevant date in July onwards, to fund those drugs. The process has taken too long. I do not want to talk about individual cases - I am sure the Deputy does not wish to do so either - but there are a couple of cases that are sensitive and time-sensitive in nature. A number of people and parties are working hard to see if interim solutions can be reached in respect of those.

Deputy Alan Kelly: I appreciate that.

Deputy Simon Harris: There is a real need to examine this matter. We have already had the very high-profile situation with Orkambi this year. Patients felt the need to mount a very public and visible campaign and, in many ways, perhaps they were right to do so. However, it placed the State in a situation where the drug companies became emboldened. That is not any criticism of the patients. I do not believe that there is any perfect system in the world for this. I meet EU counterparts quite regularly to discuss this issue because many countries are grappling with it. The current situation, whereby the Minister for Health ultimately ends up in front of Parliament asking "Where is this drug?" is not the most efficient way for patients to access them.

In advance of all parties preparing their pre-budget submissions, I make the point that the cost of providing new drugs in 2017 is something of which we must be conscious. It is really great for patients that there are so many new drugs coming on stream. It is only great, however, if we can buy them. There are many new drugs in the offing. I am engaged in the Estimates process as part of that. I want to flag that to everyone.

Chairman: Perhaps the Minister would address some of the questions the other Deputies have submitted.

Deputy Simon Harris: Deputy Murphy O'Mahony asked about home help hours, and I hope I answered that when replying to Deputy Kelly's question.

I was pleased to hear Deputy Murphy O'Mahony talk about advice and prevention. We often discuss what to do when someone gets sick but we very rarely talk about what we are going to do to keep them well. I will be launching the Healthy Ireland fund in the coming days. By means of this, bodies will be able to draw down funding if they want to do something to help make the nation more healthy. The latter is not just the job of the Department of Health. There are a variety of ways in which we all have a role to play in tackling obesity. In recent days, the Minister for Education and Skills, Deputy Bruton, the Minister for Employment Affairs and Social Protection, Deputy Regina Doherty, and I launched new nutritional guidelines for school meals. A strange situation existed until now whereby the Department of Health said, "Here are the nutritional guidelines that our children should be following", and the Department of Employment Affairs and Social Protection was funding school meals in DEIS schools, but there was no stipulation in the service level agreements to say that the school meals had to comply with the guidelines. All of the service level agreements will be in place by the new year - some

are already in place - and this will mean that we will only fund what is in line with the nutritional guidelines. This includes things such as fried food only once a week, only water and milk served with meals, not allowing items that are high in fat, sugar or salt content to be added to cereal and porridge, and greater availability of fruit and vegetables with all meals. Those are some of things we are doing. This is active schools week whereby the Department of Education and Skills is encouraging all children to get active. There is a huge body of work that has to be done across Government.

I know that Deputy Murphy O'Mahony and Senator Dolan are very interested in the area of disability. One of the issues about which my colleague, the Minister of State at the Department of Health, Deputy Finian McGrath, and I are most concerned relates to emergency placements. We are seeing a very high number of children and young adults with very complex needs who, for their own well-being and for that of their families, require emergency care. I do not want to put a cost on it but I will say that these places are extraordinarily expensive. That is the reality with which we must deal in the context of budgets. We must ensure that staff are trained and that appropriate facilities are available, and there must be liaison with HIQA so that emergency placements can be made quickly. This matter is a priority for the Minister of State, who is also working on the task force on personalised budgets, and myself. We spend a decent percentage on disability services. When one meets people with disabilities, however, they do not feel that the funding gets anywhere near them. The task force is due to complete its work by the end of the year.

I have outlined the plan for the winter initiative this year in terms of a bottom-up approach and asking individual hospitals what they want.

I will revert to the Deputy Kelleher on the issue of child and adolescent mental health services, CAMHS, in Cork and his assertion that there may be a lack of a permanent clinical governance structure. I will establish the facts and revert to the Deputy.

Deputies should be careful when referring to numbers of managers because it creates an impression that everybody is sitting around pushing papers and writing letters. When one talks about managers in the HSE, one often means managers and administrators. That may be the person who answers the telephone when a patient is trying to make an appointment. It may be someone working on a public health agenda. It may be a new clinical programme for cancer. I want to see fewer managers in the health service. Sláintecare does too. I want to see an amalgamation or closer alignment of our CHOs with our hospital groups, but we do need to keep a sense of perspective on that.

I have answered Deputy Kelleher's question about the national children's hospital and about primary care.

I want to be very clear on the issue of scoliosis. I have not, in my time as Minister for Health, ever seen the HSE more focused on resolving an issue. We got there as a country because we were shamed into taking action. The waiting lists for scoliosis have been unacceptably high for children, not just this year but in Celtic tiger times. We have put in an additional €10 million and have hired additional consultants and theatre nurses. More surgeries will be done in Crumlin and Temple Street this year combined than were done in the entire year last year. I was talking to the children's hospital group CEO as recently as this morning. We now have a situation whereby we can put in place a sustainable system which ensures every child will get their procedure within four months, which is best international practice and in line with the NHS.

The problem is that we have a very significant backlog. In fairness, when the four-month target was announced by the director general of the HSE, it was clear that international outsourcing would be part of that. We have had children go to Stanmore in the UK and have their surgeries very successfully. We have signed service level agreements in Germany and with other hospitals in the UK. I am very conscious that it will not be appropriate for every family. However, I can say that absolutely everything that can be done is being done. Deputy Louise O'Reilly will speak in a moment. I am aware of her general concerns about the issue of outsourcing. We want to arrive at a situation where we can provide a maximum waiting time of four months for all children with scoliosis in this country. That is what we are genuinely working to do. That is what the children's hospital group is working to do and is going to do. We are serious about dealing with the backlog and therefore I do not apologise for offering parents an additional route which may be Stanmore or Germany, in circumstances where it may suit. It is not ideal for everybody but we are trying to go with this in every way we possibly can. We want to see the theatre open five days a week. It will require the recruitment of an additional two consultant surgeons but we are entirely committed to that. The theatre is operating at full capacity with all of the resources that it currently has.

Deputy Louise O'Reilly: I am under pressure for time so will try to be as quick as I can. I apologise if I cannot wait for the reply; I will catch up on the transcript and will stay for as long as I can.

I might be able to help with regard to the difficulty in recruiting home help staff. As the Minister will know already, I represented home help staff for long years. They are a fantastic bunch, mostly women, and we do not have enough of them. Clearly if we made their work a more attractive area we would see an uptake. They were the only group not subject to the moratorium and their employment would have remained relatively constant, were it not for the fact that the hours kept being cut back.

According to the Department of Public Expenditure and Reform, DPER, the average cost of providing an hour of home help is €23.20. For not-for-profit or directly employed home helps, we are talking about a considerable reduction on that rate. My information is that it is somewhere around €17 per hour. We are already looking at a considerable saving. The figure of €23.20 is arrived at because there is a huge amount of outsourcing to what are effectively massive global multinational corporations. I understand that there was some dispute in the courts and I spoke to the Minister of State, Deputy McEntee before she was appointed to a different role.

It strikes me that if the Minister wants to increase the uptake in the number of home help staff, he should focus on those areas where employment is that bit more attractive, namely, in the smaller agencies. Effectively, the smaller agencies have been frozen out by the tendering and the other competitive processes, in which they cannot compete because their margins are extremely low. All of the money that they get goes directly into the provision of home help services. For the smaller not-for-profit agencies to thrive, they are going to need the HSE to give them a hand. It would be beneficial for people who need home help services, for the home helps themselves and, indeed, for the small providers if some direction could be given from the level of the Department of Health in that regard because it is a case of survival of the fittest. The people who are going to suffer are the smaller agencies.

I firmly believe that the directly employed home help staff and smaller agencies actually provide much better value for money. I do not think anyone would dispute that. There are big players in this, multinational corporations that are in the business of making hundreds of mil-

lions in profits. There should be a greater focus on the smaller operators whose margins are tight. That would, in turn, improve the take-up of people who are willing to go into that type of work. What they need is stability. I spent years in and out of the Labour Court trying to come up with a contract that would provide them with some level of stability. Clearly, if the demand is there - and it is - stability and continuity of employment should be sustainable. There is not a Deputy in the House who has not had people through their door looking for more home help hours. The example was given of a couple with an entitlement to 20 hours who are lucky if they actually get eight, nine or ten hours. The demand is there. The capacity exists for the Government to give the staff more sustainable contracts of employment. It has long been a mystery to me as to why that will not happen.

If I may refer briefly to the hospital waiting list figures and the emerging practice of publishing them at 6 p.m. on a Friday, 8 September was the last time it was done. My office was ringing to see what time the figures would be out. I understand the Minister does not do it personally-----

Deputy Simon Harris: Nor does my Department.

Deputy Louise O'Reilly: Surely the Minister has some authority to be able to instruct the people who are in charge of publishing those figures. The Minister is fooling nobody publishing them at 6 p.m. on a Friday. We all know if it was good news it would be 9 a.m. or even 8 a.m. on a Monday.

Deputy Simon Harris: There are 2,000 fewer people on the waiting lists.

Deputy Louise O'Reilly: It was not good news. The long-term waiters are up. We can see that from the Minister's own figures. The figures are up for children waiting.

Deputy Simon Harris: I take the Deputy's point.

Deputy Louise O'Reilly: Whether it is good news or bad news, the figures should be published at a reasonable time. The Minister's colleague who was responsible for the housing figures got caught on this a number of times and now those figures are published. I have written to the Minister on this matter on more than one occasion. We all know what kind of news gets published at 6 p.m. on a Friday and it is not good news.

Many of the questions I had have been asked. There is a section in the document for the National Advisory Council on Drugs but there is no money put beside it. That jumped out at me. Perhaps the Minister would be good enough to explain what that is.

The maternity strategy has been mentioned already. I would like to mention the baby friendly health initiative, which closed yesterday. Part of a maternity strategy, albeit a small enough part, is to encourage mothers to breastfeed. It would strike me as a bit counter-intuitive to cut the funding to this initiative, which I think was geared towards encouraging mothers to breast feed. Our breastfeeding rates are atrocious. They really are. It is hard in the maternity hospitals to find the space and time to sit, particularly with new mothers, to give the encouragement that is necessary. A cultural change is needed. If we are all agreed that the low breast feeding rates are something that we need to address, it strikes me as somewhat counter-intuitive to have closed the initiative. The Minister might be able to explain why that happened or if there is going to be something there to replace it.

Mr. Tony O'Brien has said on a number of occasions that the HSE does not have the capital

budget necessary to build major infrastructure projects. I am thinking in my own constituency of the new forensic hospital - it will not be called the central mental hospital any more - as well as the national children's hospital and the new maternity hospital. If Mr. O'Brien on the one hand is saying that the shillings are not there, while on the other hand the Minister is saying they are definitely going to be built, there does seem to be a disconnect. The Minister might explain why and how.

On the figures on primary care, I understand the Minister's staff will be tormented with questions on this issue. It really stumps me that while money is being made available to build primary care centres like the one in Balbriggan and while I am sure it will soon have a big ribbon placed on it and someone attending with lots of photographers to open it, there are no new staff. There is not one single extra body for Balbriggan. I have put down questions on this for the past 15 months. It is the same story with a lot of the primary care centres. While there are new facilities, there are no new staff members. If we are going to be serious about primary care, we will need to see some focus on the recruitment of staff.

I appreciate fully and accept the Minister's bona fides on scoliosis. I know people are working hard to get this done, but that theatre should be open seven days a week. There are 68 complex cases which are not suitable for outsourcing. These are kids who cannot be taken abroad. We will not get into the debate about outsourcing, but even if the wherewithal was there and the contracts were signed, there are 68 kids who cannot travel. I am not a doctor, but my understanding is they can only be treated in Crumlin because of the level of their specialty. They have all been waiting more than four months and I do not think the target will be met for them. The parents deserve to know. They are in the dark. They hear on the news that the targets are going to be met, but they look at their kids and they have no date for their surgeries. If the targets are not going to be met for those kids by the end of the year, hard and all as it is, the fair thing to do is to be honest with the parents, tell them it is not going to happen and provide them with a realistic date. Certainly, we have all been contacted by people who are in that scenario.

Can we get a figure on home help hours? While I see the global figure provided, can the Minister give the committee with a breakdown of the money spent on private, not-for-profit and directly-employed home help? When I worked in the union, we engaged someone who was much better than me with figures to go through it. That person came to the conclusion that the directly-employed and not-for-profits represented the best value for money, yet year-and-year until now, the spend has been going up on the for-profit global multinational corporations with their millions and billions in profit and top executive salaries. That pushes the overall spend up. While that is good news for the Government, which can say "Look at us. We are spending more money on home help", no additional hours are being provided because it is just buying more expensive hours from global multinational corporations.

Senator Colm Burke: I apologise to the Minister but I have a Commencement Matter in the Seanad on a health issue which I must go to. However, I will come back once it is dealt with. Respite care is a major problem. I notice the number of people who have been able to get respite care has reduced drastically. My understanding is that part of that has been the result of HIQA inspections on the basis of which facilities have been deemed unsuitable or inadequate. There is also the issue of, for example, Cope in Cork where 1,500 people attend for day care. We have a huge problem now of an aging caring population. We have elderly parents. I have people in their 80s who are looking after a son or a daughter. In one case, a man is dropping his daughter to a day-care facility every day and picking her up every evening. There are a huge number of families who, in the next four to six years, will not be able to do that. I am concerned

that the amount of respite care is decreasing. It is something we need to plan for but I am not satisfied that we are doing so. Will the Minister agree to take this matter up with the HSE? What are the projections for the next two to three years having regard to people being cared for by parents now but who will end up needing permanent and full-time care as no immediate family member will be available to look after them? How can we reverse what is happening in relation to respite care to make facilities available?

Deputy Kelleher referred to management. Deputy Kelleher referred to three people a month in management, but in fact more than 2,000 additional people have been taken on in administration and management in the HSE in the last two years. We now have 17,000 in that area. If one adds in nurse managers, there are another 7,500. Technically, we have-----

Deputy Billy Kelleher: I said it was three managers a week.

Senator Colm Burke: A week. My apologies. In real terms, it is what we have taken on in management as we have taken grades 6 and 7 out of the managerial category. It has gone from 4,700 to 5,400 in real terms. We changed how we defined "management". I do not understand why one major hospital in this country had its tenth manager in 18 years start this week. It has had ten managers in 18 years. There is something wrong there. Either the pay structure is wrong or the categorisation of that particular managerial post is not correct. No institution can operate when there are ten managers over an 18-year time period. Issues like that must be examined. We seem to have a huge problem with management and people turning over in positions. When one goes back to a person after six months to see if something has been done, one finds that one is now dealing with someone else. I am finding that very difficult to deal with in the HSE.

I want to deal with doctors and recruitment. A survey was published in the last few days which set out that approximately 80% do not see themselves working in Ireland in the medical area. We have had this problem for ten years but nothing has been done to address it. We produced the MacRea report, but things seem to be going backwards rather than forwards. For example, two thirds of doctor registrations in Ireland in 2015 were of doctors from outside the European Union. We do not appear to be dealing with that issue or to have a long-term plan. We carried out a major review in 2003 setting out exactly what needed to be done and we carried out another one in the last two or three years again setting out what we are doing, but it seems we are not making progress. We can make demands about waiting lists, but unless we have the people with the expertise to do the operations and provide the care, we are going nowhere. We seem to have our priorities wrong and to have put all of our resources into recruiting management and administrative staff while doing nothing to deal with the recruitment of front-line staff. While we seem to have come to grips with the nursing issue, where a lot of progress has been made, we have done nothing about the junior doctor issue, especially in the smaller hospitals in Letterkenny, Sligo, Castlebar, Clonmel, Waterford and Tralee, etc. We have had a particular difficulty retaining junior doctors, which is an issue we must address if we want to provide the services people want from our health care service.

I thank the Minister for dealing with these issues. I will come back after my matter is dealt with in the Seanad.

Senator John Dolan: I welcome the Minister after the summer break and his own personal happy changes in life. On pages 2 and 3, the Minister referred to cost overruns around decisions made subsequent to the national service plan. These are things like central wage agreements, etc. What we are looking at here is confined to what was in the service plan for the year and the

yin and yang around that. I have two things to raise.

Senator John Dolan: What are the actual and anticipated costs for this year and next year, respectively, for things that were not anticipated in the service plan, such as the wage agreements? I refer to things that increase the cost of delivering the service but do not shift or increase the amount of service being offered. It is important because when we look at what the service plan set out to achieve, it is not the same as the level of needs that exist for people. I will return to that in my next question.

I was happy to see page 4 of the Minister's submission which looks at the end of this year and into next year, that it refers to the service pressures being experienced. It references disability services particularly and notes that " ... the pressures in disability services largely arise as a result of regulatory compliance, emergency places and in non-achievement of targeted savings". That is fair enough at one level but I contend that there is significant unmet need which is not captured in that because it was not going to be addressed this year. That is important to say. We have 1,200 people misplaced in nursing homes. They are young people with disabilities, some of them are the Minister's own age and all of them within the age groups of the people sitting in this room. It is frightening. The average length of stay of someone in a nursing home is around two years, but it is not for these people. We have other pressures that others have spoken of such as home helps, personal assistants, therapies and aids and appliances. When we look to next year, we should remember there are many areas which are not captured that still have outstanding needs.

The Minister mentioned emergency places and expressed his concern and that of the Minister of State, Deputy Finian McGrath, on the matter. There are many more issues for young people in addition to emergency places. I mentioned personal assistants, aids and appliances, which are areas where need is growing. If we look at next year, what will be within the service plan and what will not be addressed in it in terms of outstanding needs?

The Minister reminded us of the statutory underpinning of the community services. There is no doubt in my mind - and I cannot see that anyone would credibly disagree with me - that the statutory underpinning of nursing homes on one hand, and the level of resources for community interventions on the other, is sucking people out of the community and into residential places unnecessarily and wrongly. I cannot see the statutory underpinning being done next week or the week after but something has to be done to correct that bias or tracking in the system. Something must be put in place, even if it is not ideal, to start to redress that. Ultimately, there must be more tools and more resources in the tool kit to make sure that people can stay where they ought to. It is ironic that we have a programme to get people who have lived in institutions all their lives out of them when every day there are people within the HSE - and I do not suggest they want to do this - actively suggesting to people that they go into a nursing home. In many cases, that is the only option they are given. That is a chronic issue.

I want to ask a hard question on scoliosis, and we could mention other issues. To what extent do issues such as scoliosis or Orkambi displace resources from other areas? If they are not, there must have been capacity in the system which was not used. It is a hard question because, no more than the Minister, I am not trying to suggest that these groups should not be provided with services but we need to be honest. Are we at a point where we are robbing Peter to pay Paul? It is important that we be honest about that. When one sees there are so many quantified and known unmet needs, it is hard not to come to that conclusion.

During the year, this committee invited before it some of the main umbrella and representa-

tive groups across the disability and mental health sectors. One of the themes to come out of that was that there are many things that should be happening outside the health system that have an impact. If people get a decent education, public transport, housing - they can be rhymed off - and these things work well for people with disabilities, it will take pressure off the Department of Health in time. It will not do so in time for its Estimates next year, that is clear. I am not convinced that enough space is being given within health planning to start serious conversations with other Departments. They are all enjoined in the UN Convention, the disability strategy and so on. When things are not being done elsewhere, the consequences finish in health, and worse still, people with disabilities finish up where they do not belong.

Deputy Simon Harris: I will begin by responding to Deputy Louise O'Reilly. I would be interested in following up on Deputy O'Reilly's point about home help and the not-for-profit sector. She has had to leave for understandable reasons but I undertake to do that and engage further with her on that and make my Department officials available to her to further pursue it. We will ask the HSE to revert to her with a breakdown of how much of the homecare budget is spent in the various sectors, voluntary, not-for-profit, public and private. That is certainly worth exploring.

On the day of publication of the hospital waiting list figures, last month's figures showed a significant drop in the number waiting for inpatient day case procedures of more than 2,000. The Deputy chose not to acknowledge that, which is her prerogative, but it means 2,000 fewer people waiting for operations in Ireland last month than the previous month. The figures are still too large but it was a sizable decrease in the numbers. We need a lot more of that. The figures are published by the National Treatment Purchase Fund, NTPF, a statutory agency, but I have no issue with asking them to publish them on a day other than Friday. I was working at 6 p.m. on Friday and through the weekend, as I am sure many Members do, but if it is suitable to have them published on a different day of the week, I will ask the NTPF to do so.

We will revert to the Deputy with a note on the National Advisory Council on Drugs.

On the breastfeeding programme and the baby-friendly hospital initiative, I am informed it underwent a review in 2016 which recommended the need for a revised model to be developed in line with our new maternity strategy as well as the national breastfeeding action plan. The HSE's health promotion and improvement unit is now engaging with a range of stakeholders for the development of a revised model. They have assured me that the focus in developing a revised model is not in any way related to funding or any funding reduction but is aimed at ensuring there is increased engagement across the 19 maternity hospitals in order to increase breastfeeding rates. The HSE is not reducing funding for breastfeeding and the new model, when developed, will be funded by the HSE. It is clear about that. The Deputy is entirely correct that breastfeeding rates in this country are too low. We need to ensure that we have an initiative that aligns with our maternity strategy and the breastfeeding action plan, and that will get the absolute maximum engagement across all of our 19 hospitals. The HSE has also told me that it continues to support the 19 maternity hospitals in their implementation of the World Health Organization and UNICEF's ten steps to successful breastfeeding. As the Deputy will be aware, the action plan for breastfeeding sets out the priority areas to be addressed over the next five years to support more mothers in Ireland to breastfeed and to contribute to increasing breastfeeding rates. That includes the implementation of policies at hospital level and at community level, investment in breastfeeding training and skills development for health care staff, the promotion of additional lactation specialists posts, and a partnership working to promote a culture that accepts and supports breastfeeding. I will keep in touch with the Deputy in that

regard.

On the issue of capital, the director general of the HSE is entirely correct. The health service needs more capital. We have adequate capital to deliver on our projects for this year but we, like other Departments, are engaging with the Department of Public Expenditure and Reform on the capital envelopes that will be announced on budget day but also, excitingly, on the ten-year capital plan. We have not had a ten-year capital plan in this country previously. We have had seven or eight year plans. A ten-year capital plan provides us with an opportunity as a society not only in the health area, but right across the sector, to deliver some important projects that can make a real difference. It could not be coming at a better time for the health service because we now have a ten-year policy plan in Sláintecare and we will shortly have a bed capacity review which will have looked at demographic pressures and bed capacity needs not only in the acute hospital sector, but right across the health service.

On the issue of Crumlin theatre, I do not disagree with any of the Deputies. When I came into this job, the theatre in Crumlin was shut. It was not doing any of these operations. It is open now and operating three days a week. There is an extra consultant and extra theatre nurses in place. More operations have been done in Crumlin and Temple Street combined this year to date than in the entire of last year.

We have put €10 million more into treating scoliosis. It is a major priority. I confirm we are using outsourcing not because we want to, but because we want to provide every opportunity to every possible family that requires this to make the decision that is best for their child. It will not work for some families to go abroad but the ultimate aim is to arrive at a position where we have a sustainable scenario in the public health service in this country and every child can be provided with an operation for scoliosis, or a scoliosis-related issue, within the four-month target. As for where the four-month target comes from, it is international best practice. It is what the NHS does and it is what clinical advice tells us needs to be done. We will not be found wanting in that regard. I note the Deputy has a question to me tomorrow to me in relation to the 68 patients she specifically referred to and I will engage with her on that then.

I agree with Senator Colm Burke on respite and I will ask the HSE and the Minister of State, Deputy Finian McGrath, to engage with the Senator, and, if it wishes, perhaps this committee on the projections for the next two to three years on respite requirements. The Senator was not suggesting, and nor am I, that HIQA standards are in any way bad. It is great that we have standards, but the consequence of those standards in terms of the number of places available for those requiring respite and how we will address that is a legitimate point.

We need to be very careful when members talk about manager numbers because, with respect to those in this room, they would rightly be among the first to give out if they could not get an answer to a parliamentary query, to which they have a democratic right, because included in the manager-administrative figures are the staff who answer those questions. Also included are the staff who process medical cards and those who were taken on to deliver new models of care. The cross-party Sláintecare committee stated that we need more staff to develop e-health and ICT so that we have better data, better decision-making, better processes and more accurate and efficient lists. Included in that are managers and administrators. We need a new financial system so that we can have more intelligent discussions on how the figures are done.

I am no supporter of extra layers of bureaucracy or management. I believe the HSE needs to be pared back. I want to work with the Sláintecare report in terms of how best to achieve that, but merely taking a headline figure and presuming everybody there is a manager and that,

therefore, there is no added value to the health needs of the population is far too simplistic an exercise. In fact, many of the members would be the first to put down PQs to me asking why we have not rolled out this new clinical programme, where are we at with the e-health agenda, what am I doing about the new model of care, and how the Healthy Ireland agenda is going. The answers to all of those questions often involve personnel who would fall into the category of administrator or manager. Let us absolutely have a good scrutiny of the figures, and if the committee wants the HSE here to go through it, let us do that. I would be right beside the member in supporting the assertion that we should not have extra layers of management but let us be clear about what we are discussing.

Let us also be clear - I say this to Senator Colm Burke - that the focus in the HSE on increasing front-line staff is paramount. Often when one hears conversations - stakeholders, interest groups and representative bodies do important work - one would swear that there are fewer staff working in the health service on the front line. It is, quite frankly, not true. The number of consultants employed by the HSE at the end of December 2016 was 2,862. This is an increase of 138 whole-time equivalents in the health service since December 2015 and it is an increase of 731 consultant posts in the past decade. I beg the Chairman's indulgence for one minute on this because this is neither reported nor commented on. In relation to consultant anaesthetists, in 2010, there were 348.35; in 2015, some 349.6; in 2016, some 373, and now there are 374. In relation to consultants in emergency medicine, in 2010 there were 56; in 2015, there were 82; in 2016, some 92, and now we have 93. In relation to consultant medicine, in 2010, there were 518; in 2015, some 675; in 2016, there were 723, and in 2017 there are 727. I could go on and on.

These are figures taken from the personnel census data for medical and dental in all agencies broken down by grade and group for December 2010, 2015, 2016 and up to March 2017. I will share this with the committee. The committee will see that there are some areas, particularly in dentistry, where we need to do much better but there are many areas where we have consistently seen an increase in figures since 2010. We are back to hiring staff and wanting more people to work in the health service on the front line. We are back to investing in the health service also. That does not mean everything is rosy. There are extraordinary challenges but let us not distort the reality. More people are working in consultant positions in the HSE and in the health service today than last year, and certainly significantly more than over the past ten years.

We need to do a great deal more to retain our doctors. That is why we asked Professor Brian MacCraith, president of Dublin City University, to carry out a strategic review of what we need to do to make more attractive career opportunities for the clinicians and medical graduates in this country. I spoke at a medical careers day in Dublin Castle on Saturday last where I met 500 of the new medical graduates and medical interns to talk to them about the importance of them staying in the Irish health service because we need them. It is a case of the chicken and the egg here. We have a ten-year plan for the first time in a long time. We have a cross-party view in relation to health care for the first time ever. We are reinvesting in health but we need the health care professionals to stay here with us so that we can make the improvements. We are working through implementing the three reports and the 25 recommendations of the MacCraith report. To date, five of the progress reports have been published on the Department's website. A number of issues have been addressed, including the HSE doubling the number of family-friendly places over the next three years. Our NCHD numbers continue to increase. A careers and training website has been launched and the majority of our training programmes now offer predefined rotations of at least two years to make it easier for people to plan. We have an online national employment record which has streamlined the process and the paperwork associated

with rotation. On foot of a key recommendation, the implementation of higher pay rates for new entrant consultants was sanctioned in 2015. This is an acute area. We have a lot more to do but there is a lot happening in that regard.

I thank Senator Dolan for his comments. The Senator hit the nail on the head in many ways in relation to unmet need and trying to capture what is unmet need not only now, but in the future. There are more patients with chronic diseases being treated in the health service, and there is also the rising phenomenon of people with disabilities thankfully living longer, with the resulting impact on a parent in his or her 70s, 80s or even older of having a son or daughter with a disability in his or her 40s, 50s or 60s. The issue is how the State meets those needs, and there are a number of ways that is done. I do not dispute that resourcing is one part, but also better models, of which Senator Dolan is a supporter, is a big part. I will give the example of a very small but important thing we did this year with the group, An Saol. This is a group of people who have loved ones with acquired brain injuries. They went off - I do not want to misrepresent their position - and did an analysis of the support that the State was providing to their loved ones on paper and basically asked if we could let them reconfigure that support. We do not want our loved ones, including those in their 30s, which is around my age, to be in nursing homes. If we were given control of that budget, which is already being spent on our loved ones, we could put it to much better use in order to give our loved ones a much more purposeful life, more rehabilitation and a better chance of getting back to the potential which we want them to reach. We need to do much more of that.

The Senator is correct about the fair deal scheme. Criteria obviously have to be met before a person can be admitted to a nursing home but it is concerning that we have a statutory scheme for nursing home care with the weight of a legal framework and all that comes with it in the context of entitlement and resourcing. Almost €1 billion is spent each year in that area and yet we have community supports, home care supports, home help packages and respite care which are not underpinned by statute. It varies on a geographic basis. Many people are afraid that if their mother, father or other loved one gets ten hours one week, it might go down to perhaps eight hours the next week; and it never seems to be 11 hours. These are real concerns. The Government and I fully agree with the Senator about the need to underpin this in statute. He is right that this is not going to happen overnight, nor should it since it could be very detrimental if we got it wrong. We do not want a situation where people staying at home-----

Senator John Dolan: We should ensure that there is some provision in the interim.

Deputy Simon Harris: In the interim, yes.

Senator John Dolan: There has to be a first fix that starts now.

Deputy Simon Harris: That is right.

Senator John Dolan: We can bring in regulation and do all sorts of things and then regret it.

Deputy Simon Harris: That is right, and I am sure no-one wants to see HIQA regulating somebody's mother's sitting room as if it were a nursing home. There is a balance between appropriate regulation for the home setting, which is, presumably - I am a layperson where this is a concerned - significantly different to the degree of regulation provided in a hospital or nursing home setting. We will endeavour, in the forthcoming budget, to continue the increased investment in disability services. The Senator knows that the Minister of State, Deputy Finian

McGrath, is moving mountains to try to get the UN Convention on the Rights of Persons with Disabilities ratified. We will work with the Senator on that.

Senator John Dolan: The Taoiseach said that it will be done by Christmas. I hope it is in the bag.

Deputy Simon Harris: That is still absolutely-----

Senator John Dolan: I hope the Minister of State has to do no more work on that.

Deputy Simon Harris: He has worked extraordinarily hard and shown much leadership on it, as have many people. I know it has been a long time coming. The Taoiseach's commitment regarding the end of the year is one that we are all working towards. We will keep in touch about that.

I do not want, for the reasons the Senator outlined, to personalise this in the context of any one decision made in the health service versus another, but there is an opportunity cost in any Department. Regardless of how well-funded the Department of Health or any other Department might be, if a decision is taken to do one thing, that will have an impact in terms of the ability to do another. It is just like running a house: if one decides to do something, it will have an effect on one's household budget. We are constantly grappling with that. If we buy one drug, will there be sufficient resources to all us to buy another? If we do one thing in the disability sector, will that have an impact in another sector? There will always be a degree of grappling with issues of this nature in every health service around the world. I am convinced - the Senator has heard the Taoiseach articulate this in recent days - that it cannot just be a Celtic tiger-style discussion about how much more money the health sector gets. It is important that we resource the health service. In that context, I am involved in the discussions on the Estimates. It is a matter of how the money is spent and how it is linked to outcomes. It is how we ensure that the money we spend in the area of disability delivers for people with disabilities. When I meet stakeholders and citizens throughout the country, they highlight examples of the efficiencies that could be achieved or outline better ways of delivering services.

The Sláintecare report provides a good roadmap. I do not agree with every word it contains in respect of sequences and costings but I think the committee has respected the job I have to do regarding due diligence. The report takes us on a journey for the next ten years, building on progress every year. It would give us a much more efficient vehicle. If one has an inefficient vehicle, one can increase the amount of fuel put into it but it is still inefficient. We need a better vehicle.

Senator John Dolan: I fully agree with the Minister about efficiencies. Regardless of whether a country's economy is booming, efficiencies should be on everyone's agenda. However, efficiencies are not enough to deal with the lack of personal assistance, community supports, etc. There would be better opportunity cost advantages for the health services and that is why I make the point about other Departments stepping up to the plate. There are people who cannot use local buses or the DART and who cannot get around or do things that are publicly available to others. That is a critical aspect to all of this. I apologise for interrupting.

Deputy Simon Harris: I do not disagree with the Senator. As he knows, while the Minister of State cannot be physically based in every Department, he is assigned to three. That is an initial reflection of the reality whereby there is a health need. However, that need often arises in areas in which it was not met earlier. It may not have been met as early as preschool, at an

early intervention stage or it could be a matter of enabling an older person with a disability to get the bus so he or she can retain his or her independence. It could also be a case of someone getting a job. Without getting into too much detail, it is obviously a whole-of-Government issue. The purpose of the national disability strategy is to have a document that covers different Departments, areas of Government and society in general; it is not just the job of a Minister or Minister of State in the Department of Health.

Chairman: I thank the Minister. Before I bring in Deputy Durkan, I have a few observations and comments. The document notes an underspend in primary care of several million and an overspend in the hospital service of €104 million. I think these items are related. There is evidence to show that for every €1 spent in primary care, one will save €5 in secondary and tertiary care. If we continue to underfund primary care, the natural result will be that we will end up with a more expensive hospital system. There is evidence that the attendance rate for patients at emergency departments is 40% less than in the UK. That is because we still have, for the most part, a same-day general practice service. In the general practice service in England, one can wait from ten days to three weeks to see a GP and that leads to huge amounts of work being transferred to the hospital service. In Ireland, we still have a same-day service for general practice but it is dwindling because we resourcing for primary care has been reduced and there is a huge shortage of GPs. The HSE maintains that there are only 17 or 18 vacancies at any particular time but many practices are being lost and amalgamated. In addition, services are being moved further away from patients, particularly in rural areas. The underspend in primary care has a natural consequence which, I believe, is the overspend on the hospital service. I would like the Minister to comment on that.

There has been a reduction in the funding to public hospitals from private health insurance. Ireland is unique in that its public hospital system is dependent on private health insurance coming to fund its services. The reduction in private health insurance income to our public hospitals must be having a service impact and I think that probably leads to our waiting lists being extended.

There is an issue with the number of patients seen by nurses. I presume that refers to the number of public health nurses that are available. There is huge pressure on public health nurses. There has been a 28% reduction in the number of patients seeing nurses. Is that a reflection of our difficulties in retaining and recruiting public health nurses?

Senator Dolan referred to respite care. There was a reduction of 10,000 in the number of respite nights in the first half of this year. Will the Minister comment on that? It is a huge reduction in respite care for people with disabilities.

Comments were made earlier on the targets for inpatient, outpatient and day-case procedures. Are those targets realistic? I am of the view that they are very modest and that the problem is that they are not being met. They are not being met because of bed shortages and recruitment issues. Perhaps the Minister will comment on that.

Some hospitals have good trolley numbers and others do not. I think this relates to the catchment area of those hospitals. Areas where there has been reconfiguration - such as Ennis and Nenagh, which lost acute services that were moved to Limerick, Drogheda, where associated hospitals were reconfigured, and Galway, where hospitals lost their acute services - have the highest trolley counts. That is a direct reflection of how reconfiguration was mismanaged. It also reflects position regarding catchment areas. For example, the catchment area in the midwest is home to approximately 440,000 people whereas the catchment areas of some Dublin

hospitals may not be that size and, consequently, they may not have the same pressure on their services. We have failed to reach targets for breast, lung and prostate cancer. We have failed to meet the radiotherapy targets. This must be a reflection of the recruitment and retention of staff as well as bed capacity. Soon we will only be able to provide acute care and cancer care because of the lack of beds for patients seeking elective procedures. There is significant pressure on the accident and emergency department of acute hospitals. Patients who attend at accident and emergency departments are being admitted to beds which would normally be reserved for elective admissions. I would like to hear the Minister's comments on that.

I have information that most of the money allocated to the National Treatment Purchase Fund is being spent on day cases rather than on inpatient procedures such as hip or knee replacements or procedures that would require a prolonged stay in hospital. Care authorisation notices for public hospitals were issued to 2,496 patients, but only 104 patients had a procedure as an inpatient, which is 0.4% of those who had been offered a service. In the case of people whose needs were outsourced to private hospitals, some 5,295 care authorisation notices issued, yet only 946 patients, which is 18% of cases, had their surgery completed.

In regard to child and adolescent mental health services, CAMHS, 32% of adolescents are still being admitted to adult institutions for care. That is quite an extraordinary figure. Perhaps the Minister will comment on it.

Deputy Alan Kelly raised the issue of St. Joseph's Hospital in Ennis. I know it is *sub judice*. St. Joseph's is an old hospital and issues arise because it cannot provide services that could be provided in a new hospital. There is a proposal to build a 50 bed unit in St. Joseph's to replace the existing beds but the planning, design, procurement and building of such a facility is a four-year process. That is too long for an essential service. Will the Minister comment on those observations and questions?

Deputy Bernard J. Durkan: I apologise for my late arrival but the traffic was hectic this morning.

I agree with the Chairman's observation on the need to ensure that adequate private health insurance patients are diverted towards the public hospital service. I had a recent case where a patient was refused access to the public hospital system because they had private health care insurance. That is the policy. The person opted for the public hospital because they had been there before, but because it was an emergency case and the person had private health insurance, access was refused. I do not think it is a good practice at all to refuse to admit private patients and I brought this case to the attention of the Minister privately.

The availability of hospital services has been the subject matter of discussion for as long as I have been around. It requires further attention. We need to look at glitches that cause hiccups in the system, backlogs in accident and emergency departments and long waiting times for admissions. We need to look at the extent to which the needs of those who present at accident and emergency departments as an emergency should have been met by admission as an inpatient or to day care. I also came across a situation very recently where a patient was being recycled through the accident and emergency department and discharged on more than one occasion to a rural hospital, instead of being admitted to hospital for the necessary procedure. This should not be happening. The staff in the accident and emergency department should be able to come to a conclusion that these patients are in severe pain and require urgent attention. There must be a reason that this care is not provided. We need to assess what impedes the flow through the system.

It was brought to my attention that a consultant who wishes to work in the public hospital system found that he could operate for the whole day in a private hospital whereas in a public hospital he could only perform two procedures because of the lack of theatre staff, an anaesthetist or some other personnel. There was some reason that he could not operate for the whole day. The Sláintecare programme will go down the tubes unless we can identify the cause of problems and remedy them. We need a trouble shooter in the system who can pinpoint what will go wrong long before it becomes obvious. I will not refer to the issue of scoliosis that was referred to already. Imagine what it is like to be disabled and to have to live in cramped conditions. Why was it not possible to identify the scale of those requiring treatment for scoliosis long before it became a public issue? We all heard about it at the same time. Those requiring treatment for scoliosis were in the system as they had been assessed as requiring urgent treatment. We need to conduct an audit of the deficiencies in the system in order to identify how we can intervene in a positive way to ensure that it meets the requirements of the patients as quickly as possible and in so far as possible.

Our health service is not the most poorly funded health service in Europe by a long shot. I am trying to avoid criticising the services directly. We tend to comment negatively on the GP, hospital, day care and accident and emergency services so that nobody wants to take up a GP practice when it becomes available for the simple reason that the system is being dumbed-down and there is no future in it. Nobody wants to take on a role where there is no future. That should be known to everybody. I am aware of a recent case where there was only one applicant for a job. If we do not address the problem, young professionals will seek to work in places where they do not have that hassle and also have to deal with the ancillary issues such as the cost of houses which are twice as expensive as elsewhere. The GP does not only have to pay for the practice, but also pay for a house.

Members have referred already to the fire fighting issues and the need to stamp out the crisises as they occur. We need to identify the causes instead of wasting our time fighting them. That is not a criticism of any person, but we need to take action.

If we are attempting to deal with the high cost of drugs in Ireland on our own, we will not succeed. It will not be solved on the basis of an amalgam of 13 or 14 EU members states applying an average price across member states. Effectively the major drug companies blackmail governments by feeding the drugs into the system in the first instance, and achieving patient satisfaction because the new drugs are a significant advance on what was available previously. Then the drug companies can demand a ransom figure to supply them. The orphan drugs and ransom figures will be associated in future as it is what is happening. No single government across Europe will be able to address such a problem.

There is the question of agency staff, which has not been raised. I know, having been a member of a health board for some time, that there is always a need for some agency staff. However, the degree to which the system has become reliant on agency staff is now alarming, as are the costs associated with them. I realise locums and emergency staff must be paid more to fill needs at a particular time. However, the more we become reliant on those staff, the more expensive and less efficient the system becomes, with less patient satisfaction. The patient likes to know the person he or she is dealing with and that the same person is there all the time. The patient would immediately raise questions if a third person is introduced to the process and it suffers as a result.

There are a couple of other matters I will address before concluding. We have the ability to provide a good health service in this country and everyone is striving to do that. We need to

recognise that we also need to achieve efficiencies in the system. I have my own views and the committee has heard them. The Health Service Executive, HSE, does not deliver and it is not suitable for the delivery of services throughout the country. There is no use referring us to the greater Manchester area because we have a comparable population and it should have the same type of service. That is not true as there is a vast geographical difference and many miles must be covered by people. Hence the difficulty in providing services to the rural areas to the extent we have come to expect.

We know that we have been able to provide services. Perhaps we were not able to do it as well as we would have liked but we were able do it. It was still possible to get emergency access, although I know that is still possible if one gets through the accident and emergency department process I spoke of. There are competing demands nowadays that we all recognise within Departments and between Departments. We know all that. If we are to look after the health care requirements of the community, we must be able to assure the people that the tax-payers' money being spent on the delivery of health services to the public is adequate to meet people's concerns and demands in future.

Deputy Simon Harris: I thank the Chairman for his questions. I reiterate the point on the primary care budget, amounting to more than €1 billion per year, which is seeing a shortfall for this point in the year of €7.7 million. It is my expectation and that of the HSE that the full primary care budget will be expended this year. I reassure the committee in that respect. I very much take the Chairman's point and I made it myself in recent weeks, when people endeavoured to misrepresent publicly the fees paid to GPs as though the fee paid to a GP equated to the income of a GP, which it certainly does not. A GP in this country effectively has to run a small or medium business, hiring staff and practice nurses. The GP is paid to provide a service, and in my view that service is one of good value and it is valued by our citizens.

Members are correct in that a new contract for GPs is badly needed and we do not want to lose what is good about general practice in this country. It is the one area where we do not have a waiting list. I do not agree with those in general practice who believe this means we can never extend free GP care to children. I do not believe that and that can happen, although it must be done as part of a bigger discussion about resourcing and the sustainability of general practice into the future. That is why when I became Minister for Health, rather than just wanting to speak to GPs about free GP care for children and nothing else, I asked to have the conversation as part of a broader discussion, asking what we need to do to help general practice to be sustainable into the future and addressing the challenges in rural areas and areas of urban deprivation with respect to the availability of GPs. If we are to resource general practice better and invest in general practice, as the Chairman and Deputy Durkan noted, we must consider the benefit of that to the acute hospital sector.

I believe we can all agree that here patients must present at an acute hospital but in other countries they simply never would have to arrive there. That is not a criticism of patients as they no more want to be there than the man in the moon but they have nowhere else to go. The Chairman is a GP and knows this but I am told by GPs all the time that they can do more but can only do it if they are resourced to do more. They are up for doing more. I do not want to say too much more because of the ongoing discussions. On the GP training, I make the point-----

Chairman: I am glad the Minister made the distinction with GP fees.

Deputy Simon Harris: It is important.

Chairman: It is income, but a substantial proportion goes to running the practice.

Deputy Simon Harris: Yes.

Chairman: Unfortunately, the financial emergency measures legislation applied to the whole fee rather than just the income component. That has been the single most destructive factor in general practice over the past five years. As Deputy Durkan implied, one cannot fill a GP practice now because the financial model is unsustainable and not viable because the emergency legislation was applied to the gross fee rather than just the income component. It is a critical factor in the manpower issues in general practice now.

Deputy Simon Harris: I appreciate the Chairman's view and that of other GPs in this respect. It is a point legitimately raised by GP organisations. I do not want to negotiate publicly on discussions that are taking place as part of the broader conversation. I want GPs and the people to hear this broader message. I am talking about expanding services and making general practice more accessible to people. People may have lain awake last night wondering if they had the €60 to bring a child to a doctor today. I see such people in my constituency office and other members probably know them too. They do not qualify for a medical card or a GP visit card and they worry about making ends meet. I will not do something that gives with one hand but takes something away with the other. If GP care is made free, there could be a very long waiting list to see the GP. We are working on a multi-annual basis to put in place a programme of reforms and investment in general practice that will enable the Government to pursue some of its democratic mandate in terms of extending eligibility to free GP care but which will enable GPs to deliver that in a manner they believe is sustainable. When I became Minister, I could have continued down the road of saying I just wanted to talk about free GP care for children. We have not done that and the Chairman's involvement with the programme for Government broadened that discussion on the GP contract. We will continue with that.

On the issue of GP training places, it is disappointing all the training places were not taken up this year. There is no getting away from that. There are approximately 16 vacant places. That needs to be seen in context. In 2009, we trained 120 GPs per year and this year we will train 170. We are continuing to expand and we will continue to expand the number of GP places. The point made by Deputy Durkan is crucial. If we as a country or society look to speak about the health service only in a negative fashion, it will not do much to encourage others to get involved. This is a point about the chicken and egg. To improve services, we need more speech and language therapists, nurses and doctors to take up work in the Irish health service. If we had had this conversation five years ago, it would have been somewhat academic as we would not have been recruiting. We are now recruiting and these people need to know they are working in a health service that values and appreciates them. They need to know there is a clear policy direction that will not keep changing. Sláintecare is the basis for that. Equally, I need those people to work in the health service and provide balance.

Chairman: I have spoken to the Minister about postgraduate education for general practice on a number of occasions, particularly the appointment of GP tutors to run our postgraduate medical education scheme, which is essential to keep GPs up to date and informed about new procedures, policies and protocols as well as keeping them educated. It is very hard to understand how that cannot be funded to allow GPs to increase their knowledge and take pressure off the hospital services by operating in a modern way. It is essential that it is funded.

Deputy Simon Harris: I am actively looking at it. I recently met a delegation on the issue. The Chairman is very passionate about it and he has brought it to my attention. I need to look

at it in the context of the fact we do not fund postgraduate training for other elements of the health service, so there is an equity piece here. I am looking at it and I do hear feedback, not just from the Chairman, and passionately from him, that it is a model that works. I am looking at it in the context of budgetary matters.

In the context of the private health insurance issue, the Chairman is correct that the income reduction level is a factor in the growing deficit. I am pleased to say there is not a service reduction. The Oireachtas, for better or worse, passed legislation that is very clear on how this operates. Private health insurance companies have a different view and that is causing a real challenge here. It is something we are going to have to look at from a variety of perspectives.

On the public and private piece, it is interesting that the Taoiseach's maiden speech in this House was on decoupling public and private medicine. That is not to suggest that people with private health insurance do not have a right to have private health insurance or that doctors do not have a right to practice private medicine. However, it is hard - the Sláintecare committee arrived at this point - at a time when emergency departments, EDs, are crowded and public service waiting lists are lengthy, to work out how someone with private health insurance can use a public hospital bed ahead of someone who might have a greater clinical need but cannot afford private health insurance. It is easy to say that as a political point of view and it is one I share passionately. I spoke about it at the Health Management Institute, HMI, conference this week. If one were to say in the morning that one was going to decouple public and private health care, one would blow a hole in the health budget of about €700 million, so this is something we need to look at. Sláintecare calls for an impact study to be done, which I think is a really welcome body of work, and I have announced this week that it is my intention to proceed with that. We have to ask ourselves, when we have public beds in public hospitals, why public patients cannot access them while private practice in the public hospital can continue unabated. That is a real challenge.

I fully take the point on the question about some hospitals performing well and others not. I am not in any way endeavouring to dispute the fact that in certain parts of this country there are certain challenges that may or not exist in other parts. The point about reconfiguration is correct. I support the reconfiguration measures that took place, but they took place on the promise of more beds at some point in the future, and in some places those beds have yet to materialise. I get that. We are in discussions about the 96-bed block that is needed for the University Hospital Limerick. I do not want my crucial point to be lost and I do not think it is lost, namely, that if one just looks at hospitals as stand-alone hospitals, it is evident that all hospitals are seeing increases. All hospitals are facing a situation with more patients being older and therefore staying longer, and all hospitals are seeing more chronic care. Despite this, Beaumont Hospital, Connolly Hospital, St. Vincent's University Hospital, Cavan hospital, Mayo hospital - without any extra beds and with more patients - have seen fewer people on trolleys. I am not making it overly simplistic. They are the INMO figures from January to July this year. As a people and political system, we need to ask why that is. I know why it is. It is because of good patient flow and really hard work throughout the hospitals. That is not to suggest that other people are not working really hard, but it is about people saying not just that they need more resources, which they do, but that there are also things they can do better within the hospitals for patients.

The figures are stark. A total of 4,282 people were on trolleys in Beaumont from January to July 2016, but this year that was halved to 2,193. It is still far too many people on trolleys but it is clear that something was done in that hospital and this is the learning I am trying to embody in the system. We have to scrutinise that. One could say it is a big Dublin hospital but look at

Cavan. There used to be an emergency department in Monaghan but there has not been for a number of years, yet Cavan General Hospital for the same period this year saw 207 people on trolleys compared with 621 last year. I am purposely cherry-picking the good ones. There are many on this list that have gone the opposite way, so while I do not suggest in any way that the trolley situation is getting better, I am suggesting that some hospitals are using good practice and we should learn from each other. Any system that does not learn from another is not good. When we talk about hospitals and trolleys, we need to point out that some hospitals are making significant progress.

Deputy Louise O'Reilly: I accept some hospitals are making progress but the Minister freely admitted he is not quite sure what the reasons are. It is good that he is not trying to take any credit for that.

Deputy Simon Harris: I am not trying to take credit at all. I am putting it down to the hospitals.

Deputy Louise O'Reilly: I know. It is down to people working hard, in some instances despite the efforts of the Government.

Deputy Simon Harris: I was not going that far either.

Deputy Louise O'Reilly: I appreciate that. I said I would say that. I did not say the Minister would necessarily agree with me. Challenges are faced in those hospitals where trolley numbers are high. Overall the trolley figure is not good and the Minister would not claim it is-----

Deputy Simon Harris: No.

Deputy Louise O'Reilly: -----and it is getting worse. When a former Minister, Mary Harney, declared a national emergency during the last Fianna Fáil Government, there were 469 patients on trolleys. Another former Minister, Senator James Reilly, said we would never again see 569 people on trolleys, and then we reached 615. It is clear that while there may be hospitals that are working well or better or doing innovative things, there are also hospitals that need a hand. We have to examine the reasons some hospitals are clearly struggling. It is not for want of effort on the part of the staff. The Minister knows that.

Deputy Simon Harris: Yes.

Deputy Louise O'Reilly: In any accident and emergency department in any hospital there will be staff working to the absolute top of their capability. People are giving way more than their contracted hours and going way beyond the call of duty. As well as looking at the successes - sometimes when we note the rate of increase has slowed, it is classed as a success - we have to look at what those hospitals that are struggling need because it is not for want of effort on the part of the staff who are working hard. As part of the review, the Minister cannot simply look at one hospital that is doing well or a group of hospitals that may be performing better. That is just one measurement. There could be other areas to be considered. The Minister will also have to look at the hospitals that are struggling and look at what specific supports they may need because they are operating in the same environment as the other hospitals and additional beds were not added. If it is not for want of effort on the part of the staff, and we can all agree that is the case, then we must look at what is working in one hospital and what is not working in another hospital and try to examine if the hospital needs support. Very often the supports may not be hugely expensive but they may make a big difference. In this regard I suggest that the

Minister should talk to front-line staff. I know the Minister does, and I do not suggest he does not, but I urge him to listen to the suggestions of front-line staff. I welcome the winter initiative being a bottom-up rather than a top-down approach because very often the people who are on the front line have some of the answers and can provide a valuable resource if they have the headspace to think.

Deputy Simon Harris: I do not disagree with Deputy O'Reilly on this issue. This is a really important point because we never have this conversation. When something goes well in some hospitals and it does not in others, we always look at it from the perspective of what extra supports the hospitals need, and many hospitals need extra supports. We have used the example of Limerick today in terms of reconfiguration and extra pressure. It has to be accepted that some hospitals are being better run and managed than others. Some hospitals are making sure that come Friday evening, patients who are clinically well enough to go home are discharged. In other hospitals, the number of patients discharged is extraordinarily minimal because proper processes have not been put in place. I am not just talking about the rate of increase slowing but about the numbers actually halving from January to July in a minority of hospitals. All I am saying is we always talk in the health service about the bad performers. At some point we have to decide to take the good ones and find out what is going on with the four or five really good examples. That is the only point I was making.

Deputy Louise O'Reilly: The hospital group to which the Minister referred is operating an integrated waiting list management system. That was reported in the media.

Deputy Simon Harris: Yes.

Deputy Louise O'Reilly: I am still waiting for an update that was due in August in relation to the proposals we made. I appreciate that those in the Department call it a single integrated waiting list management system. We shorten that and call it Comhliosta. The Department officials can have that name if they wish. If it is proven to work, and it has been proven to work-----

Deputy Simon Harris: It does work.

Deputy Louise O'Reilly: I know I do not need to do a job to convince the Minister. If it has been proven to work, even in a small number of hospitals, then logic should dictate that it can and should be deployed nationally.

Deputy Simon Harris: I have no wish to damage Deputy O'Reilly's street cred, but I think we are making the same point.

Deputy Louise O'Reilly: I do not think I have any street cred. The Minister is all right.

Deputy Simon Harris: This is the point. We know the RCSI hospitals group can reduce waiting lists not by any one hospital or consultant owning the waiting list or the patients on the waiting list but by utilising the small level 2 and level 3 hospitals that work. These are the conversations I am having with the HSE. The Sláintecare report refers clearly to this. I was going to make this point to the Chairman. He has spoken about arriving at a point where the unscheduled care demand becomes so great that we do not have the capacity in our health service to deal with the elective work. I have spoken about this publicly. I believe each of our hospital groups need to look at the idea of elective-only centres. The private hospital sector is doing this already. The new deputy director general of the HSE is John Connaghan. He was working in National Health Service Scotland. Let us consider what they did in the Scottish NHS. The public health service there bought up a hospital in Glasgow and used it as an elective-only

centre. This drove down the waiting lists because it decoupled trolleys from the waiting lists. I will be looking at that in the context of all the various discussions with budgets and capital plans that we are engaged in now.

I am conscious that there are many questions and I have no wish to delay too much.

Chairman: Did Senator Burke want to come in?

Senator Colm Burke: I wish to go back to the hospital management issue. Earlier, I raised the question of a tenth manager being recruited in 18 years. There must be a problem in the smaller hospitals because there seems to be a vast turnover of administrative staff at senior levels. I appeal for this issue should be looked at. In fairness, no matter how big or small the hospital, the hospital manager is dealing with a complex job involving people who are doing the cleaning, porters, catering staff, nurses, junior doctors and consultants. There is skill in managing all these interest groups. We seem to have a difficulty in retaining senior staff in the smaller hospitals. I am calling for that to be looked at because if we do not have continuity in management, we will have failure in many other areas as well. This should be looked at.

Deputy Simon Harris: I assure the Senator that it absolutely is being looked at and will be looked at. This is relevant not only at hospital level but at hospital group level as well. We have seen what happened when recruitment campaigns were run for managers. In some hospitals people did not apply. I want to look at international recruitment as well. We have already seen a successful international recruitment campaign for the two new deputy director generals of the HSE. It is a question of bringing in outside experience of what works. It is not all stick. There has to be a carrot too.

I also want to look at how we support people in managerial roles. Senator Burke made a point earlier about training. The HSE has done a number of things recently to help. We simply appoint the hospital manager and then say he is on his own and send him off to it. We must ensure people have skill sets and feel part of a support network in terms of having advice. They need to be able to learn from the best experiences in hospitals that are going well. We will absolutely look further at that.

Chairman: I wish to make another comment before the Minister leaves the discussion on the acute hospital sector. The Minister asked why some hospitals are performing better than others. Apart from some hospitals having a greater catchment population than others, there are numerous other issues. Some hospitals have senior decision-makers on the floor on a 24-7 basis. It is vital that hospitals have 24-7 senior decision-makers. Junior doctors do not have the experience or capacity to make the important decisions about admitting or discharging. That is critical.

Deputy Simon Harris: I agree absolutely. Again, it is back to management needing to ensure we have a complement of rostered senior decision-makers doing the rounds, visiting the wards and discharging patients who are ready and who want to go home at the weekends. It does not take a rocket scientist to work out why our trolley numbers drop as we get towards the end of the week and into the weekend and then begin to take off again. We are meant to have a 24-7 health service in this country and it requires a 24-7 presence. There is active interest from us all, from the Minister, the hospital manager, the HSE and the consultants. We all have to pull together in this regard.

I have no wish to come across in any way as being overly negative. I have seen really good

examples from consultants and managers going above and beyond what they are asked to do. I am simply pointing out that it is not a homogeneous group and we need to stop talking about it as though it is. We need to learn from the good and the bad and discover the reasons. We need to share that knowledge. I am not asking these questions in the abstract. We are undertaking these activities as we speak.

We do not want to have a perverse incentive whereby people are concerned that if they perform well when it comes to a winter initiative, they will be told they do not need help because they are doing well. We need to convey the message that if someone does well, they get more support to do even better.

Chairman: There is another factor relating to the integration of primary and secondary care and greater communication between primary and secondary care. Many patients would not end up in hospital if their problem could be solved through day case or ambulatory care services as opposed to being brought in to be investigated. They should be investigated with a view to not being admitted. If there was early access to diagnostics and a specialist opinion, many admissions would be avoided.

Model 2 hospitals are not being used to their maximum capacity. There are three model 2 hospitals in the mid-west, but they are not being given the resources to fulfil their potential. They have great difficulty in recruiting staff and in securing 24-7 diagnostics, but that would allow patients to be looked after in those hospitals as opposed to going to the tertiary centre, which is the general hospital in the area. There are ambulance bypass protocols. If a person falls on the street in the mid-west, he goes to Limerick. There is no question of him going to a model 2 hospital. Those model 2 hospitals could be used as triage centres. For example, if a person is suspected of breaking a hip in the mid-west, he will not be X-rayed in a model 2 hospital. He must go to the regional hospital to be X-rayed. He may or may not have a fractured hip but he is now lying on a trolley for a number of hours or days waiting for a diagnosis that could have been delivered in a model 2 hospital. These hospitals need to be given greater resources to maximise their potential.

Deputy Simon Harris: There were other questions but I am afraid we could keep going. There is a great deal to be said and it is an important conversation.

I addressed the issue of respite already when Senator Burke was out of the room. I addressed it in response to Senator Dolan. The Chairman raised it as well. There is clearly an issue. That is not in any way to criticise HIQA, because HIQA is an independent regulator with a job to do. There is clearly an issue with the HIQA standards being applied and having a direct impact on the number of respite places available. That is the point Senator Burke asked us to analyse. When he was out of the room, I undertook that we would do that in terms of unmet need and projected demand this year, next year and the following year. I indicated that we would get the Minister of State, Deputy McGrath, and the HSE to liaise with the Senator in this regard. We cannot have one arm of the State doing one thing without the other arm preparing to see how best to respond. I take on board that point.

A question was asked about the National Treatment Purchase Fund. The Chairman is right to say the bulk of the work of the NTPF this year is day case work. The numbers have increased somewhat since the document became available. The figure referenced of 1.26 is now up to 2.35. We have seen, through the various initiatives of the HSE and the NTPF, that under phase 1 of the NTPF this year, 2,000 appointments were accepted and 1,112 patients were treated. Under phase 2, which is the inpatient day case insourcing initiative, we have seen 910 appoint-

ments accepted. Under the inpatient day case outsourcing initiative, which is a third phase and the final part of this year's plan, we have seen 235 appointments accepted. That is in addition to the outpatient waiting list action plan and the HSE inpatient day case waiting list plan.

Another committee member made a point earlier and it bears repeating. I hope people will be pleased when they see the NTPF initiative for this year, especially with the insourcing element. This will come to the fore especially as we get to the inpatient procedures. Reference was made to hips, knees and so on. I believe there is significant scope, through the NTPF, to insource several of these procedures. Without getting into granular detail, the likes of Cappagh National Orthopaedic Hospital and theatres there receive revenue from the NTPF through an insourcing initiative. I do not want people to think that, ideologically, I am approaching this in the sense that the NTPF should outsource things. Deputy O'Reilly always thinks that when she is talking to no one in particular.

Deputy Louise O'Reilly: I imagine the Minister is looking at no one in particular

Deputy Simon Harris: It is a regular conversation we have. There is a requirement to outsource several of the day case procedures, especially because we are coming into a time of additional winter pressures in our hospitals. This is relevant for public hospitals that do not have emergency departments, the hospital in Cappagh being the obvious one. It could apply to some of the smaller model hospitals the Chairman referred to, as well as others. We are actively discussing insourcing in terms of building on it further for 2018. I am sure there were other questions.

Chairman: I referred to a 28% reduction in the numbers of patients seen by public health nurses.

Deputy Simon Harris: As the Chairman stated, this is a recruitment challenge. The community intervention team activity is running ahead, which assists to some extent in that regard. However, we continue to face a challenge in recruiting public health nurses.

On child and adolescent mental health services, CAMHS, the percentage of bed days used in CAMHS inpatient units is above the expected service plan level of activity. However, as the Chairman noted, the admission of children to CAMHS units is below target. This is due to acknowledged difficulties in retaining and recruiting specialist staff not only here, but throughout the European Union. Efforts are under way in that regard.

Chairman: While I accept the Minister cannot speak about an issue that is *sub judice*, on the proposal to build a 50-bed unit at St. Joseph's hospital in Ennis, surely the four-year planning process can be shortened? One year has been provided for design, procurement, and tendering. Surely the planning process for an essential facility should be shorter than four years? I ask the Minister to examine that case.

Deputy Simon Harris: I instinctively agree with the Chairman and I will revert to him directly on the specific capital project. As he indicated, the other issues are *sub judice*.

I believe I answered most of Deputy Durkan's questions. However, the Deputy has frequently raised with me the need to collaborate on the issue of medicines procurement. If Ireland endeavours and other countries grapple with the issue separately, we will go around in circles. We have made progress on this issue since I last met the committee. I have signed the Valletta declaration which commits Ireland to working with six other countries to engaging in, at a minimum, joint horizon scannings and health technology assessments in which we can

share information about the pipeline of new drugs and work together on the issue. The declaration also leaves open the possibility of jointly procuring drugs. The challenge in this regard is that not every drug that we need may be needed in another country. This occurs for a variety of reasons. Each signatory to the Valletta declaration has been asked to put forward one or two drugs which it is interested in jointly procuring. It will be interesting to see if some common drugs emerge. This is the only way to grapple with this major issue.

Ireland and other countries will shortly arrive at the point where patients find that new and innovative technologies have become available and could improve their quality of life or extend their lives, but they are unable to access them because of the pricing structure. We have done good work with the Irish Pharmaceutical Healthcare Association, the drug representative body here, on savings. The issue, however, is not only the current drug bill but the pipeline of drugs, about which I am particularly concerned. The Valletta declaration is a concrete step which we took after years of talking about collaborating internationally. I hope it will yield benefits for patients.

Deputy Bernard J. Durkan: The point I have made on this issue is still valid. We should have the benefits of the Single Market as regards the costs of drugs. We have the benefits of access to the Single Market in most areas but not on this issue. With a population of 500 million, the European Union is a major market and Ministers and health agencies in the European Union must capitalise on this when purchasing drugs on the market. If we do not do so, the more developed countries will pay the price of being isolated in the marketplace.

Deputy Simon Harris: I will continue to make that point at meetings of European health Ministers. However, given that health is a national competence, instead of making that point, on which I agree with the Deputy, and waiting for progress, I decided that Ireland should show leadership and join other European countries of a similar view by moving ahead with the Valletta declaration. It is open to other member states to join and everyone is welcome, so to speak. I want to avoid a scenario where we do not move ahead because we are waiting on EU bureaucracy and discussions that could go on forever and a day.

Deputy Bernard J. Durkan: I raised the issue of agency staff, specifically the efficiency of using them and their cost. I also asked question on a troubleshooter and the viability of the structures we have to deliver services. The Minister is aware of my views on that issue.

Deputy Simon Harris: Yes, and the Deputy is aware of my views on it. The structure is not fit for purpose. Let there not be any doubt that I believe the Health Service Executive in its current guise will not be the HSE of the future. I fully accept the necessity to have a national health service body and to drive maternity strategies, standards, cancer programmes, procurement and so forth at a national level. However, we also need to have many responsibilities devolved to hospital groups and community health organisations. Under Sláintecare, it is envisaged that the hospital groups and CHOs will be aligned and this the approach we should take.

To refer to the issues raised by the Chairman, under this approach, we would have a cluster of hospitals, primary care facilities and community settings that can support each other. For example, one hospital will do one type of operation better that others, while another facility may be able to perform another function better. They can link in via the primary care system. Sláintecare landed in the same place as I did on this issue and we have a consensus on the structure we would like in the health service. To use my words, rather than the words used in Sláintecare, this structure should be a slimmed down national HSE with functions that it carries-----

Deputy Bernard J. Durkan: It would incorporate regional structures to maintain continuity.

Deputy Simon Harris: That is correct. There is a very clear direction of travel in that regard.

The Deputy is also correct on the issue of a troubleshooter. As I indicated, we have just hired a new deputy director general in charge of operations who brings with him vast experience from the Scottish health system. The Scottish national health system is often held up by political parties in the House as a destination that we would like to reach. As the chief of operations, the deputy director general will bring a fresh pair of eyes and new approach to a number of issues. I hope also that he will embed some of his knowledge across the system. Perhaps the Deputy will repeat his final question.

Deputy Bernard J. Durkan: It was on the reliance on agency staff at all levels.

Deputy Simon Harris: The HSE does not desire to have agency staff. It is a recognised fact, however, and one the Deputy also acknowledged, that such staff are sometimes required, particularly in smaller hospitals where it is proving extraordinarily difficult to recruit permanent consultants. That is part of a broader conversation. To take nursing as an example, we have made clear that we want to convert agency posts to permanent nursing posts. We have a clear policy and genuine commitment to replacing agency staff with permanent staff. In the year to date, the HSE has spent €180 million on agency staff. I will send the Deputy a table showing how this figure compares with previous years. While agency staff are not as desirable as permanent staff, many of our hospitals are reliant on them. Notwithstanding the challenges we see in the acute hospital setting, I would not fancy seeing the scale of those challenges without agency staff.

Deputy Louise O'Reilly: The Minister is aware of my views on agency staff. Greater efforts can and should be made to convert agency staff to directly employed staff. While the former do fantastic work, they do not provide the best value for money. Agency staff in the ambulance service and elsewhere find it very difficult to break into the HSE. They are knocking on the door. The employees the HSE is contracting for service have clearly attained the relevant standard as the HSE does not contract people who are not capable or qualified. Barriers to entry include the registration process with CORU for people wishing to move here from abroad. We also have to consider whether working in the heath service is an inviting prospect. The HSE can be a fortress whereas it should be easy for people to join the health service.

I apologise if the next issue I raise was discussed in my absence. A table on page 38 of the document shows that the number of adult referrals seen by the mental health service increased by approximately 10,000 in 2017. We see increases throughout the service. Will the Minister confirm that adequate funding will be provided to deal with these increases?

Deputy Simon Harris: The page numbers are obviously different in the document I have. The Deputy's question relates to additional demand on mental health services.

Deputy Louise O'Reilly: The number of adult referrals has increased by 10,000. Will the Minister confirm that funding will be provided to deal with this increase? Obviously, more referrals mean more resources will be necessary.

Deputy Simon Harris: With the normal proviso that we are involved in a budgetary and Estimates process and that these decisions are made on budget day and within a service plan, it

is our intention to continue to increase mental health funding. If a service need is there, it will be our intention to endeavour to meet it. I have to wait to budget day to fill it.

Chairman: I thank the Minister and his officials, Mr. Greg Dempsey, Ms Fiona Prendergast and Mr. Martin Woods, for taking the time to attend the committee to provide us with a comprehensive review of expenditure to date.

The joint committee adjourned at 12 noon until 9 a.m. on Wednesday, 4 October 2017.