DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 22 Samhain 2017

Wednesday, 22 November 2017

Tháinig an Comhchoiste le chéile ag 9 a.m.

The Joint Committee met at 9 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Bernard J. Durkan,	Colm Burke,
Billy Kelleher,	John Dolan.
Margaret Murphy O'Mahony,	
Kate O'Connell,	
Louise O'Reilly.	

I láthair / In attendance: Deputies Joan Collins and Róisín Shortall and Senator Rose Conway-Walsh.

Teachta / Deputy Michael Harty sa Chathaoir / in the Chair.

Business of Joint Committee

Chairman: We have a quorum. I propose that we go into private session to deal with some housekeeping matters. Is that agreed? Agreed.

The joint committee went into private session at 9.10 a.m and resumed in public session at 9.30 a. m.

Review of the Sláintecare Report

Chairman: The purpose of this morning's meeting is to engage with the Minister for Health, Deputy Simon Harris, and the Secretary General of the Department on progress made on the implementation of the key recommendations contained in the Sláintecare report prepared by the Committee on the Future of Healthcare. The report was launched on 30 May last and this is an opportune time to review progress. On behalf of the joint committee, I welcome the Minister, Deputy Harris, Mr. Jim Breslin, Secretary General, and Ms Laura Casey, principal officer.

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

I invite the Minister to make his opening statement.

Minister for Health (Deputy Simon Harris): I am delighted to before the joint committee today. As the Chairman stated, I am joined by the Secretary General, Mr. Jim Breslin, and Ms Laura Casey, also from the Department of Health.

I am grateful to have the opportunity to discuss the Sláintecare report with the committee. I will set out the process that we are engaged in to act on the report and will outline some of the steps already taken to advance recommendations in the report.

I wish to reiterate some general things I have said since the idea of the all-party committee was first mooted. I believe them even more so now that the committee has completed its work. The establishment of the committee provided a unique opportunity and space for all parties to put aside political ideologies and policy differences, and to work together in the best interests of the people they serve. The committee members did not sidestep this important task and lived up to their mandate. I again take this opportunity to acknowledge and thank the committee members and all those who engaged in consultation with them throughout the process.

This is the first time in our history that we have achieved consensus at a political level on the future direction of our health system. These opportunities do not come around too often and I am determined to harness this political consensus and to work with colleagues across the political spectrum and with all stakeholders to move forward on a programme of health reform that will ultimately benefit the health of our citizens, those who work in our health service and our society.

The process of reform will only succeed through the commitment and buy-in of all stakeholders to a shared vision. We have started on a solid foundation of unprecedented political consensus and must now seek to build consensus across the system, including clinical consensus and buy-in to the necessary reforms.

We are all aware of the challenges of implementing change in our health system. Healthcare delivery is a complex endeavour and we in Ireland are not unique in encountering a variety of challenges. We now have an opportunity to learn from our own past experience, as well as international experience, and to design a programme of reform and the necessary supports to engage stakeholders across the system and sustain momentum over the coming decade. Moving towards a universal health system for all citizens is a transformational change in the Irish context. Every party in this Oireachtas has now signed up to that. We want to create a universal health care system and it will take ongoing commitment. Our continuing motivation will be our shared and agreed ambition to better serve the people of the country and to help shape a healthier future.

It is important to set out the context for the Sláintecare report. The Committee on the Future of Healthcare was established in recognition of the fact that our current health system, despite notable achievements, is not well placed to meet the demands of future generations. We need to design a system today to meet the many challenges now and into the future.

These challenges are well cited: our population is rising and the increase in those in older age groups is particularly relevant; there is a growing prevalence of chronic disease; health inequalities and unmet need are increasing; and there is an ongoing challenge to attract and retain the right skills mix and numbers in the workforce.

Committee members will have seen the report recently published by the ESRI, Projections of Demand for Healthcare in Ireland, 2015-2030. The picture painted in this report is stark and highlights the challenges that face our system in the next decade and reinforces the case for change. The main findings of this report are that over the years 2015 to 2030, the population of Ireland is projected to grow by between 14% and 23%, adding between 640,000 and 1.1 million people to the population. Furthermore, the share of population aged 65 and over is projected to increase from one in eight to one in five and numbers of people aged 85 and over are projected to almost double. It is a very welcome development that people are living longer but we need to be cognisant of it.

Because of these changes in demographics, demand for health and social care is projected to increase across all sectors, with the greatest increases for services for older people. Demand for home-help care and for residential and intermediate care places in nursing homes and other settings is projected to increase by up to 60%. Demand for public hospital services is projected to increase by up to 37% for inpatient bed days and up to 30% for inpatient cases. Demand for GP visits is projected to increase by up to 27%.

We also know that the nature of the illnesses faced by the Irish population is changing. Now

approximately 60% of Irish people have one chronic disease and around 25% have two or more chronic diseases. Chronic disease requires a different type of care that is preventive, ongoing - not a once-off treatment - and managed close to home.

Ireland is not unique in the challenges that face our system. It is clear that the world around us is also changing rapidly and similar demographic and disease challenges face countries worldwide and particularly in western Europe. Rapid changes in mobility and technology present new challenges such as the spread of infectious diseases and the risk posed by antimicrobial resistance. The development of knowledge and technology also presents opportunities to fight diseases that were previously debilitating and to access new therapies and better medicines. As the world will continue to change in ways we cannot yet imagine, we must have the flexibility, ability and leadership to respond. We must be innovative in thinking about how to best serve the Irish population into the future. The work of the Committee on the Future of Healthcare in producing the Sláintecare report has provided us with the collective space to reconsider our direction and start to plan for a healthier future.

I will now turn to the report itself. The recommendations in the Sláintecare report are grounded in eight overarching principles that I fully endorse. These support a reorientation of the health service towards a high-quality integrated system providing care on the basis of need and not ability to pay; a universal system providing the right care in the right place at the right time, provided by the right people. The principles describe a system that is modern, responsive and integrated, comparable with other European countries, one that inspires long-term public and political confidence. In order to achieve this system the report highlights the need to place the patient at the centre of a system that delivers care which is timely, provided free at the point of delivery and provided at the most appropriate, cost effective service level with a welcome emphasis on prevention and public health. The report also points to the need to create an enabling environment for reform. This is an environment where the workforce is appropriate, accountable, flexible, well resourced, supported and valued, with accountability, value for money and good governance at the heart of the system. I believe that this describes a healthcare system that will command the support of the people of Ireland and will meet their needs.

It is also important to highlight that a number of the recommendations in the report are supportive of current policy developed by successive Governments. A number of initiatives are already in train. In particular, the report strongly supports a real shift in our model of care, moving away from a hospital-centric approach to one which is focused on providing the majority of care in the community. Ministers for health have been talking about this back to the days when Dr. Rory O'Hanlon was Minister for Health. Many of these ideas have been around but perhaps we have not pulled them all together and had a real consistent programme of reform. That is the major benefit of the Sláintecare structure.

A range of other ongoing initiatives are given strong endorsement in the report including: the Healthy Ireland strategy, the eHealth agenda, integrated workforce planning - I was delighted to launch our new national strategic framework for health and social care workforce planning last week - a robust clinical governance framework, enhanced community nursing, integrated care programmes, and current strategies in the areas of maternity care and mental health. The report has highlighted that these issues should form the basis of creating the health service we all want to build. The support for these initiatives is helpful and can add greater impetus to their successful delivery.

I will now outline decisions taken with Government and work that is under way to develop a programme of reform to take forward the proposals in Sláintecare. When I spoke in the Dáil

Chamber in June during the debate on the Sláintecare report, I was clear in my conviction that the publication of the report would come to mark a critical milestone in the history of our health service. I was also clear, as is the report, that we needed to allow time to reflect and deliberate on the findings of the committee and consider how best the vision and spirit of the report can be realised. This process of consideration is well advanced.

In July, the Government agreed to move forward with the establishment of a dedicated programme office and specifically the recruitment of a lead executive for that Sláintecare reform office. This marks a critical first step in gearing up for a significant programme of reform and demonstrates our commitment to this process. Budget 2018 allocated €1 million for the Sláintecare office in line with the report's recommendation of €10 million over ten years, €1 million a year.

The recruitment process for the head of this office is under way and is being managed by the Public Appointments Service. The Public Appointments Service has actively begun the searches it needs to do to ensure we have the best person to do the job. It is essential that we are positioned to attract candidates of calibre for what will be a considerable reform programme. An extensive national and international executive search is being undertaken as a first step in this recruitment process, with the aim of attracting very senior candidates with a strong track record in implementing large-scale programmes of reform. In following the debates of the Committee on the Future of Healthcare I am very conscious that getting the right person with the right skill set is a key challenge. It is appropriate the Public Appointments Service is carrying out a national and international executive search to ensure we have the right person in place.

In parallel with this process, I have also been tasked by Government and the Oireachtas with developing a response to the report and a draft implementation plan for consideration by Government by the end of this year. People ask where is the draft implementation plan. The report tells me to produce it by the end of the year and I will have it by the end of the year. This process is seeking to translate the Sláintecare report into a programme of action for the next ten years. The report itself recognises there is a need to take the vision and plan and put it into a programmatic series of concrete actions. This is why it asks me to put in place an implementation plan. It will also consider issues that arise in designing such a programme, including key actions, deliverables, costings, timelines, and interdependencies. It is widely acknowledged in the Sláintecare report that more detailed consideration of these issues would be required, and this work is under way and it will be delivered on time.

This process is being led at the most senior levels in the Department and the HSE, and also involves close engagement with the Departments of the Taoiseach, Finance, and Public Expenditure and Reform. The involvement of these Departments was a key recommendation of the report, as we need strong cross-Government political leadership. We do not need Sláintecare to be just the job of the Department of Health. We need buy-in and investment from other Departments in terms of a whole of Government approach, and this is what is happening. In recognition of this, the Cabinet held a special Government meeting in Cork last month, focused specifically on health care reform and the Sláintecare report. This is quite important. When I was appointed Minister for Health, I read a column which stated those who become the Minister for Health are often treated by the rest of their Cabinet colleagues as though they have Ebola, and that it is that person's job to fix the health service and no one else will go near the Minister in case he or she gets infected by all the challenges of health. The fact the Government itself held a dedicated meeting on Sláintecare and health reform in Cork I hope sends out a very important message on how seriously we are taking this and about the fact the Taoiseach, Deputy

Leo Varadkar, wants to see a whole of Government approach on this. This is a view shared throughout the Government.

Later this week, there will be further discussion at the Cabinet committee on health, chaired by the Taoiseach, on the development of the implementation plan. Sláintecare and the development of an implementation plan is the specific agenda item at the Cabinet committee on health this week chaired by the Taoiseach. In fact, it will be held tomorrow. At the meeting in Cork, I was tasked with continuing the process of developing a response to the report for the Government's consideration. I was pleased to receive Government approval to move ahead with a number of actions recommended in the report. These include the initiation of an impact study on the removal of private practice in public hospitals. One of the transformational recommendations of the Sláintecare report is that we would move towards a universal system of health care, which would address the current inherent unfairness in our system when it comes to accessing care. The report rightly points to the issue of private practice in public hospitals in this regard. The committee acknowledges that it will take time to change this system, that careful consideration will need to be given to the impact of such a change, and that there will be a considerable price tag attached, but we cannot shy away from the core issue that when the public system is under severe strain, when emergency departments are full and waiting lists are in a challenging position, it is hard to defend an arrangement whereby private practice continues unquestioned in public facilities.

In its report the committee asked that I carry out an impact study and I am pleased to say this is under way. I have appointed Dr. Donal de Buitléir as chair of an independent expert group to examine the issue. The review group will be strong and balanced, bringing extensive experience and expertise in health care, including in hospital management, and also in governance, finance, human resources and employment law. Membership of the group will be finalised in the coming days, when I will publish the names of all of its members. The group will specifically examine the potential benefits and the potential adverse consequences that may arise in the separation of private practice from public settings. I will be asking the group to pay particular attention to the existing nature, level and role of private practice in public hospitals; the negative and positive aspects of private practice in public hospitals including access to health care, equity and the operation of public hospitals; what practical approaches might be taken to the removal of private practice from public hospitals, including a timeframe and phasing; possible impacts, both direct and indirect, immediate and over time, of removing private practice from public hospitals, including but not limited to impacts on access; hospital activity, including specialist services, funding, recruitment and the retention of personnel; and any legal or legislative issues that might arise. The group will conclude its work within nine months of commencing and by the end of next summer.

I am conscious we are having this meeting this morning in the aftermath of an "RTÉ Investigates" programme, and while I have clearly outlined the actions I have taken in relation to implementing the recommendations of Sláintecare in this regard, I want to say most consultants and doctors I meet in the Irish health service, and most people I meet in the Irish health service, do not just work the hours they are contracted to work but work well above them. We all know doctors in the health service about whom we are not worried about underworking but overworking. Equally, what we saw last night on our television screens in the case of some doctors was immoral, unfair and brazen and it needs to be rectified. Not just on foot of last night's programme, but for the past number of months, the Department has been engaging with the HSE on the need for a more robust monitoring system. If a nurse turns up late for work or does not work his or her hours, if a health care assistant does not work his or her hours, and if people in

the public sector or private sector do not work their hours, they know all about it. We cannot have a continuation of a culture of deference to anybody working in our health service. Immoral, unfair and brazen is how I would describe what I saw last night, but I want to say this in the context of acknowledging it is a minority of people working in our health service. I expect the HSE as the employer will now formally investigate each of the cases shown on television last night. I expect this to happen and I am aware it will happen. We cannot have a situation where people are paid for hours they do not work. It would not be tolerated in any other workplace and it would not be tolerated in the health service at any other grade. The culture of deference towards consultants in some hospitals must end. I say this in acknowledging the fact many of our doctors work well above and beyond their contracted hours and it is important to say this.

A public consultation on the future alignment of hospitals groups and community health organisations, CHOs, will take place. The Sláintecare report endorses the need to achieve greater alignment between hospital groups and CHOs. I spoke about this when I appeared before the committee. We all know that different health service management structures have been put in place over the years, and we all know that while finding the ideal structure will not suddenly solve all our problems, having the wrong structures will certainly undermine our chances of successfully developing a coherent, efficient and integrated system.

I welcome the emphasis on integrated care that is embedded in the report, and I believe that aligning our delivery systems will ultimately help the system to move towards a population-based approach to service delivery that will help provide a more integrated service for the citizens of this country and help those in the system to better understand and manage health outcomes. Having hospital groups and CHOs operating on this basis will facilitate collective performance and accountability arrangements based upon pre-arranged and shared goals, budgets and incentives.

I am conscious that structural reforms can be disruptive and that we need to avoid unintended consequences. For this reason, I have agreed to undertake a consultation process to hear the views of people working in our health service, of those who represent them, and, most important, of patients. I will commence this consultation process by the end of the month.

There are also plans to establish a governing board to oversee HSE performance. I spoke about this when I appeared before the Sláintecare committee. I am very pleased it appears in the Sláintecare report. We need to re-establish a board in relation to the HSE. This will require legislation and I hope to have a board, with very strong competencies across key areas, established in 2018. Current governance structures in the HSE are not appropriate. They were only ever to be there as an interim measure. The director general of the HSE has spoken about this, as have I, and as has the Sláintecare committee. I intend to publish very early in 2018 legislation to establish a board based on competencies that can bring greater accountability and governance structures to our health service. With the support of the parties in the House we could pass that legislation quite quickly and ensure the board is populated and in place with proper skills and expertise as early as possible in 2018.

Taken together with the consultation on alignment of hospital groups and CHOs, these are significant foundation steps in moving towards an evolution in our health care system. I am very aware of the need to bring decision-making closer to the point of care delivery and provide a counterweight to unnecessary over-centralisation, which impedes service responsiveness, but I am equally aware of the need to maintain a national-level focus in certain areas. It is a balance. What we can do locally in the region we should do and what we need to do nationally, in terms of standards and performance, we need to do. These matters are under consideration as

part of overall reform proposals.

It is important to mention that funding for new initiatives in budget 2018 was closely aligned with proposals in Sláintecare. This allocation of funding shows the commitment of the Government to supporting key actions necessary for reform. These include a new primary care fund of €25 million. In his speech on budget day, the Minister, Deputy Donohoe, was very clear that this investment represents the start of a period of multi-annual investment in primary care and a GP contract. There is additional funding of €25 million for home care and transition beds, which is an important element of the Sláintecare report, reductions in medicine and prescription charges costing over €17 million, which will see prescription charges and the monthly drug payment scheme costs fall in January, targeted funding for waiting list reductions and, as has already been mentioned, funding to establish the Sláintecare programme office.

The agreement of capital expenditure allocations over the next four years has also allowed me to increase significantly the financial investment in ICT. The topic of ehealth was a very important part of the report. This will increase from €60 million next year to €85 million in 2019, €100 million in 2020 and €120 million in 2021. Thus, the budget for ehealth will more than double over its current level, allowing for significant expansion in digital health and ICT systems.

I also announced that in 2018 I will undertake a process of engagement with representative bodies of contracted health professionals, such as GPs, pharmacists, opticians, dentists, aimed at putting in place a new multi-annual approach to fees, commencing in 2019, in return for service improvement and contractual reform and in line with Government priorities and Sláintecare priorities for the health service. This will support the development of a new modern contract with GPs and other primary care providers, and is in line with emphasis on this area in Sláintecare and issues raised at this committee over recent meetings.

I have heard from many understandable frustration with the pace of the response to the Sláintecare report. We all want to reform the health service but it is a ten-year plan. There is a great deal of groundwork to do to make sure we can succeed on this. We can all agree that sometimes the pace of policymaking and decision-making is not what it should be, but in this case I do not believe that the criticism is fair or realistic. I am firmly of the view that a careful and proper process of consideration is vital so that this does not all fall over when we hit the ground running in 2018. The proposals in Sláintecare represent one of the largest programmes of reform not just in the health sector, but in the public service more generally. They reach into the very operation of our health care system, and into our systems of entitlement and access. Neither the change that is required to deliver on these proposals nor the challenges that will be encountered in making them a reality should be underestimated.

We need to properly consider these challenges and seek to learn from past reform mistakes - this is not the first time we have tried to reform the health service - and we need to look at past reform in this regard internationally as well. Our success will very much depend on the formulation of an effective implementation path. Implementation requires planning and identification of strategic decisions. It requires putting the right people in place. This is the process that I am engaged in at present with Government colleagues, my Department and the HSE. Having read commentary in this regard, I personally attest to the commitment of all those, most particularly, my Department, involved in this work. In recent days, there have been challenges to the bona fides of this commitment and I want to refute that in the strongest possible terms.

The Government has charged me and my Department with developing a draft implemen-

tation plan by the year end and that is what we will do. We are deadly serious about it. I am receiving the wholehearted and enthusiastic commitment of the civil servants in the Department of Health in the detailed implementation planning which is under way. I thank my staff for that. We have started extensive staff briefings to inject a degree of excitement and enthusiasm across both the HSE and the Department of Health that, when I am gone, when new Governments come and go, this is the plan that we all signed up to and that we will deliver collectively over the next ten years.

I look forward to returning to Government with a detailed response and the draft implementation plan. I very much look forward to coming back here when I have that, perhaps in January or whenever the committee wishes, so that we can discuss the detail of the implementation plan, the timelines and the progress we will make in 2018 and in subsequent years.

Chairman: Before I open the meeting to other members, I myself will comment.

The role of this committee is to hold the Minister, the Department of Health and the HSE to account on the urgent need for health reform as laid out in the Sláintecare report and this will be the lead committee to oversee that reform programme.

If evidence of the need for reform was needed, it was clearly illustrated on last night's "Prime Time" programme which demonstrated and exposed the damage of mixing public and private care in the public hospitals. It leads to unfairness and inequality of access. One must ask why it takes a television programme to illustrate these deficiencies in the health service. It was a shocking indictment of management and clinical governance and it illustrates the perverse incentives to doctors and hospitals to have private patients treated at the expense of public patients in the hospitals where private patients and public patients compete for the same beds.

It also illustrated the pressure on the public hospitals to treat more private patients as these hospitals depend on their income from private health insurance to fund their public services. This process is entirely wrong and denies access for public patients to the public hospitals.

The programme itemised the payments to consultants for hours not spent in public hospitals, but a far greater cost is to patients who are denied services because of failures to provide a consultant-led service in the hospitals. It leads to increasing waiting lists and an unacceptable unmet need. It means that senior decision makers are not present on the floor to make important clinical decisions and that leads to inefficiencies in the service.

To address this problem, we need to have a cultural change - the Minister himself referred to it - in the way we manage the health services and this involves accountability and sanction. The public-private mix is one of the greatest barriers to health reform and has to be tackled. It demonstrates the absolute need for legislation to hold hospital management and clinical management to account. The Minister, in his statement, states that we need to give "careful consideration" to this issue but he does not state that he is determined to definitively eliminate private practice from public hospitals. I hope the Minister will not be influenced by the powerful lobbies that will resist that change.

The Sláintecare report points to reform and gives it a proper direction. It is ambitious and radical and it has to be in that it has to bring equity of access based on need, not the ability to pay. It is about fairness and justice for all. The provision of adequate care is a human right and I believe patients are being denied human rights in the waiting lists that they have to endure, and the denial of treatment and procedures. We must have a single-tier service provided on the

basis of need, not the ability to pay.

A single-tier service, as outlined in the Sláintecare report, has cross-party consensus and this should not be ignored or easily dismissed in the reform process. We do not need to have a piecemeal implementation of the Sláintecare report items which are in keeping with existing Government policy while the Minister procrastinates on the difficult but essential elements of reform which will require extraordinary political commitment if we are to develop a health service which we can trust and which can deliver quality care.

Six months have passed since this report's publication yet we still await the appointment of a lead executive and the setting up of an implementation office. We await legislation to reconstitute the HSE and the setting up of a Cabinet sub-committee in the Department of the Taoiseach to oversee the reform process. Without these essential components the reform process is not going anywhere.

The Cabinet sub-committee needs to be at a level of the Taoiseach and needs to have the power of the Taoiseach and the interconnectivity between the Department of Finance, the Department of Public Expenditure and Reform and the Department of Health. This high-level political commitment will be needed to oversee the implementation office and give it political protection in delivering Sláintecare.

We must start drawing up legislation which will underpin the statutory basis of Sláintecare. We need legislation on a national health fund; legislation for a new Irish Sláintecare Bill and legislation for accountability in the Department of Health and the HSE; and, legislation to set up national standards in clinical governance. None of these is forthcoming to date. They are of vital importance if we are to establish a proper functioning health service which can deliver quality care. It is only then that we can start to effectively invest in health reform. If we do not have this legislation, investment in health reform will be wasted.

We should not let complacency develop. Already key deadlines have been missed. The implementation office, under the auspices of the Taoiseach, has not been set up. Recruitment of a lead executive at the level of Secretary General has not happened. Staff with expertise in implementing change have not been recruited. A detailed implementation plan has not been published six months after the publication of the Sláintecare report. We need to combat resistance to change, both in the Department and the HSE and in the wider health service.

Several members of this committee and I, as Chair, were members of the Committee on the Future of Healthcare and we know the recommendations of the Sláintecare report. The reality is that all milestones set out to date in the implementation section have been missed. This indicates that the reform programme is stalled and has gained no political momentum to date.

The Minister was quite correct in stating that the Committee on the Future of Healthcare did not sidestep its responsibility in this report. We expect the same commitment from the Minister. We need commitment at the highest political level to form the Sláintecare reform process.

It appears that the Minister was second guessing many of the recommendations of the report. Deputy Harris was calling for space and time to reflect and deliberate on and consider the report. The Minister has had six months to do so yet we have had no completion of any action recommended in the report. The programme office has not been set up, a missed deadline. A lead executive has not been appointed, a further missed deadline. The failure to develop a draft implementation plan is also a missed deadline. A Cabinet sub-committee chaired by the

Taoiseach and consisting of the Departments of the Taoiseach, Finance, Public Expenditure and Reform, and Health, has not been established to give political power to the implementation of the Sláintecare report.

Apart from the often proposed reorientation of the health service towards primary care, the disentangling of private care from public hospitals is an essential component of Sláintecare, as illustrated by the television programme broadcast last night. While a chairman to oversee the independent review has been appointed, the review group has not yet been populated, which is another missed opportunity.

The report refers to the realignment of community health organisations and hospital groups. The decision to put this proposal out for a consultative process will again delay reform. I referred to the legislation to reconstitute the board of the Health Service Executive, which has not been brought before the Dáil and is unlikely to be presented to the Houses before 2018. The timeline for this Bill is much too vague.

The Sláintecare report makes extensive reference to ehealth and information and communications technology systems and the Minister spoke of increased investment in ehealth. The HSE's chief information officer resigned from his post last week and stated the Government's failure to fund the programme was frustrating, noted that funding was in limbo and indicated that there was an absence of funding certainty coming from Government. These were some of the reasons for his resignation, which hardly engenders confidence in funding the Sláintecare reforms.

The unwinding of the financial emergency measures in the public interest for contract holders, including general practitioners, will not take place until 2019 at the earliest. Coupling the unwinding of FEMPI with contract negotiations will not encourage young graduates to take up general practitioner contracts before 2020, nor will it address the manpower crisis in and crumbling of our general practice network. These factors are already affecting the delivery of primary care and placing greater strain on hospital services. This decision will inhibit meaningful reform for several years and delay the transfer and reorientation of our health service towards primary care.

The pace of response to Sláintecare is much too slow. Implementation milestones and processes to achieve these milestones are nowhere near completion. Six months after the publication of the Sláintecare report, a draft implementation plan is several months away. Legislation must be enacted in several areas to give structure, responsibility, accountability, transparency and answerability to the health service. I expect the Minister to pick up the pace of reform. The joint committee will invite him back in the new year to give us an update on how he is progressing the Sláintecare reform programme.

Deputy Simon Harris: The Chairman can expect me to pick up the pace, and I certainly will, but I expect to be held to account in respect of timelines to which the Committee on the Future of Healthcare adhered. The Chairman criticised the lack of an implementation plan for Sláintecare but the committee, on which he sat, asked me to produce one by the end of the year. As I indicated, a plan will be produced by the end of the year. I ask the Chairman to hold me to deadlines that have been established.

On the Chairman's fear that consultation will delay the process, perhaps the recommendation that we engage in consultation should not have been included in the Sláintecare report. Generally, it is a good idea to consult people who work in the health service and their represen-

tatives. This is also the finding made by the committee in its report.

Tomorrow evening, the Cabinet committee chaired by the Taoiseach will meet again in Government Buildings to discuss the issue of Sláintecare.

While the joint committee has privilege in this place, it is important that we do not misinterpret the reasons people move to new jobs. I am aware of the reasons for decisions made by individuals to move from one place to another. There is a legitimate issue with regard to capital funding. Mr. Richard Corbridge was an excellent chief information officer for the health service and I am very sorry we lost him. There is a number of reasons for people's decisions to move to new jobs. As I outlined in my opening statement, we will double the capital budget.

The deadlines for legislation the Chairman stated I missed do not appear in the Sláintecare report until years 2 and 3 of the plan. I share the frustration expressed by the Chairman and, having spent so many hours working on Sláintecare, it is appropriate that he is committed to ensuring the report is implemented in full. I intend to assure him by my actions and through regular appearances before the joint committee to engage on Sláintecare. I welcome his clarification, if it was required, that this committee is the lead committee on the oversight of the Sláintecare report. The Chairman will hold me to account on this matter and I expect to be held to account. We will deliver Sláintecare. It is not a case of procrastination. The report states we should procrastinate in that we should draw up a draft implementation plan, which I will do.

On the issue of vested interests, when it comes to the public-private mix my view is crystal clear, as is the Taoiseach's view. He stated the Government does not believe the public-private mix is appropriate and that Ireland is an outlier in terms of international norms. I want to see the public-private mix ended. It is my view that we should end private practice in public hospitals over the length of the Sláintecare plan. That is my genuine belief and it is also my policy. However, the reports asks that we do an impact study on the matter, which is what we will do. I take the Chairman's points.

In terms of vested interests and equity of access, we have equity of access issues in secondary care and we have access issues in primary care. I am determined to address these issues and Sláintecare is the best vehicle for doing so. I assure the committee of my commitment and that of the Government to working with it and delivering the plan.

Chairman: I thank the Minister for his response. I invite members to make comments and observations.

Deputy Billy Kelleher: I welcome the Minister and Mr. Breslin. The Committee on the Future of Healthcare spent considerable time drafting the Sláintecare report. I appreciate the work done by the Chairman and secretariat in providing support to the committee, members of the committee and the witnesses who appeared before it. The report includes timelines to which we hope the system will adhere, regardless of who is responsible for doing so in the period ahead. This should not be a matter for individuals as it requires corporate buy-in by the public service administration to ensure reform is seamless, regardless of which party is in government. This is especially the case given that the agreement on Sláintecare was reached by an all-party committee. The difficulty we have had for many years is that health policy has been jagged, to say the least, in terms of political parties and manifestos.

One could be forgiven for blaming the political side for the direction the health service has taken and the fact that policy was reversed or changed or retrenchment took place. This is a

difficulty for those who are implementing policy. That being said, we cannot completely exonerate those on the policy side of the Department with regard to the implementation, not only of the Sláintecare report but also of previous policies.

The Chairman referred to the "Prime Time Investigates" programme broadcast last night. The programme showed an abject failure in policy and to ensure contracts were enforced. The director general of the Health Service Executive, Mr. Tony O'Brien, stated in a confidential email to the then Minister for Health, the current Taoiseach, that large voluntary teaching hospitals were in some instances breaking the rules in how they went about recruiting consultants. The contract introduced in 2008 set a limit of 20% on the percentage of patients most public hospital consultants could treat privately. However, in his email, Mr. O'Brien stated the percentage division between public and private was "a farce in practice". This email was sent to the Minister's predecessor.

None of the members of the joint committee will have been surprised by last night's "Prime Time Investigates" programme. We were shocked, however, to use the words of the Minister, by how immoral, unfair and brazen some of these individuals were. While some people may be immoral and brazen and their behaviour will have unfair consequences, the bottom line is that contracts must be enforced and the Department and HSE are failing to do so. The Department funds the HSE which informed the previous Minister and, I presume, current Minister that it could not enforce consultants' contracts and the position was farcical.

One of the principal problems at the heart of all of this was the decision in 2014 to redesignate all beds in public hospitals for private care. This resulted in a profound shift and created a perverse incentive at the heart of the public health system to treat private patients in public beds. We must quickly address the issue of contract enforcement. I do not believe the HSE can do this because it is caught with a perverse incentive. It has to fund the hospitals and it does that by putting public patients on waiting lists and private patients in public beds. Whoever carried out the review for the Minister did not get to the heart of the problem because public waiting lists are increasing and some consultants do their private work elsewhere while junior doctors oversee their public waiting lists. The Department of Health seems to be incapable of enforcing it. What is it doing about it? The HSE is in a bind with stretched budgets. The fact that many public hospitals have a huge revenue stream from treating private patients ahead of public patients will not address the issues we are discussing, to ensure people are dealt with on the basis of clinical need.

"Prime Time" last night showed a Mrs. Comber, a patient in Limerick, trying to get a cataract operation. I watched the programme a second time because I thought I was seeing things initially. A Deputy from west Cork is busing people to Belfast because they cannot get into Cork University Hospital for ophthalmic surgery. At the heart of our public health system is a system that perversely incentivises public hospitals to put public patients on waiting lists and private patients in public beds. Many consultants are in on the game as well. I do not believe that either the organisation that Mr. Breslin oversees or the HSE is capable of enforcing these contracts because they are incentivising the public system by doing this. We need an independent evaluation and enforcement of contracts, separate from the Department of Health and HSE. The Health (Amendment) Act 2013 allowed for charging in all public beds for private patients.

At the heart of the Sláintecare report is the necessity for an impact study on the removal of private practice from public beds. I argued for that and I was delighted that it was included in the report because the committee believes that this is creating difficulties in the public health

system. Equally, to strip it out in one fell swoop could have a negative impact, just as the present situation has a negative impact. We have to tread carefully to ensure we do not undermine services.

On fiscal smoothing of capital spend to comply with EU budgetary rules, there has been poor capital expenditure over the past ten years in the health service and there will be a huge deficit in the future with demographic changes, aging population, more chronic disease and chronic illness all placing more demands on our public health system. We will need to spend a lot of money on the capital side. The Economic and Social Research Institute, ESRI, said we need at least 2,000 extra beds. The Minister's capacity review will be coming out soon which will probably seek more than that because we need more than acute beds. Do we need to renegotiate with the European Union how we account for capital expenditure? Four years is too short for fiscal smoothing a hospital. In any other business that would be done over a prolonged period. The system is front-loaded and that will diminish the capacity of the State to invest in major infrastructural projects that are needed because of the deficit rules.

Has any thought been given to that issue that is retarding the State's capacity to invest in long-term capital spend? Have any additional resources been outlined or highlighted in the Department of Health to oversee this? I know there will be a recruitment process for a lead executive. There has to be a draft implementation plan. Have any senior officials been specifically designated to this particular project to make sure it is up and running? The process is being led at the most senior levels in the Department and the HSE and also involves close engagement with the Departments of the Taoiseach, Finance and Public Expenditure and Reform. The committee was considering this and felt at one point maybe it should be separate from the Department of Health because we can argue that the overseers may have other interests because of budgetary constraints and not wanting to bring political embarrassment to their masters and I do not mean any disrespect to the Minister or to Mr Breslin but I am referring to the system. Will the system bring forward reports and recommendations that the political masters simply cannot implement and are there difficulties and conflicts of interest there? What additional resources have been given to the Department of Health by way of personnel to start the process of implementing the reform outlined in the Sláintecare report?

Deputy Louise O'Reilly: I welcome the Minister and the officials to the meeting. Before making my remarks I wish to thank the Chairman, the secretariat, witnesses, the Trinity College team and committee members because we did good work. We put great effort into the report and that is fairly obvious on reading it. There are those of us who would have liked to see the report go further in some areas but in the interests of consensus everybody was capable of coming together and making the necessary accommodation with each other.

It would be silly for us to sit here and pretend we did not all watch the "Prime Time" report with horror last night. I raised the issue of stretch targets with the Minister, over a year ago, on 16 November last and it strikes me that what will happen over the next couple of days will be an attempt to somehow shift all of the blame for this onto the shoulders of consultants. Anyone who knows me knows that I have a history in the health service and would not always have been on the side of consultants but in this regard I think the Department and HSE need to step up and take some responsibility because the perverse incentives came from the political system. The stretch income targets were a political instruction. Effectively, the Minister is presiding over a system that not only tolerates the use of public money, facilities and public contracts for the provision of private health care but actively encourages it, mandates it and insists upon it.

What I saw on the television last night did not in any way, shape or form surprise me. Of

course I was disappointed, shocked and upset, particularly to see a woman forced to sell some of her belongings to pay for private health care, but I could see very clearly this is a political matter as well as a service matter and it would be unfair to people working in hospitals to attempt to paint this as anything other than what it is. In fact the incentive and the mandate to carry out this private work come from the political system. The Minister referred to a culture of deference to consultants. That may or may not exist but they work in the system that the Minister and the officials have designed. The contracts were announced by the then Minister in the Fianna Fáil-Progressive Democrat Government, Mary Harney. They came from the political system. Nobody in the HSE invented this. It came from the political system and the political system needs to step up and take some responsibility for it as it is continuing. It has been one year since I raised the issue, on which the Minister has said some work has been done. He has not been working on it for the past year, but he has certainly been more than well aware of it.

The Minister has stated he is worried about staff in the health service over-working. I hope this will extend to the working time directive. I have spent a considerable number of hours and days with the working time directive implementation group. We encountered nothing but resistance, as seen in the political system, in trying to make progress on it. There are tens of thousands of staff in the health service who are working way beyond their contracted hours. I am sure they will be very glad to know that the Minister is worried about the matter, but I also think they would probably prefer to know what he is doing about it because there is a recruitment and retention of staff crisis. That is not the fault of the workers on the front line who are doing their very best. Rather than express concern, the Minister might outline in concrete terms what he proposes to do. I sincerely hope it is not more of what he has been doing up to now because, clearly, it is not working.

I have gone through the Minister's statement. He mentioned ehealth. We all read the newspapers at the weekend. Mr. Richard Corbridge will be a great loss to the project. I question the commitment of the Department and the HSE to moving forward in a meaningful way with an ehealth strategy as we are far behind the rest. I know that members of the Government have got into trouble in comparing us with international standards, but it is true that we are well behind when compared internationally. Clever and all as the statisticians in the Department are, I do not think they will be able to pull statistics out of the bag that will contradict what I have said. We live in a state in which patients still bring their files with them. If one goes to Holles Street hospital, one will see women walking in with their paper files. It is nonsensical. Much of what is contained in the Sláintecare report is predicated on being able to make progress in that regard. The fact that we cannot is very disturbing.

The Minister has said he wants to translate the Sláintecare report into a programme of action for the next ten years, which is very much to be welcomed, and that the process is being led at senior levels in the Department. Will he indicate the individuals who will be responsible for driving the process?

As regards the public consultation on the future alignment of hospitals, I have said previously that sometimes what we say here is directly contradicted by what is done outside. On the one hand, the Minister says he wants public consultation on the future alignment of hospitals and, on the other, we read that trauma services will be withdrawn from a number of hospitals, which has caused nothing but panic. People view this as downgrading and services being removed from their communities and it causes a huge amount of worry. On the one hand, the Minister talks about public consultation and, on the other, about moving ahead in making some serious changes; I will not use the word "reform" in this case. Will he outline what is supposed

to come out of the public consultation process? It was stated the board would be established in 2018. Will the Minister give us an indication of the position in quarter one or quarter two-----

Deputy Simon Harris: It is up to all of us-----

Deputy Louise O'Reilly: The Minister can take it that there will be no unwillingness on the part of members of the committee. The funding targeted for waiting list reduction initiatives is €75 million. Will the Minister give us a breakdown indicating where that funding will be spent?

On the robust monitoring system that will be put in place, again, I go back to the stretched income targets. This is something I raised in November and December 2016 and January, February, March, June and September 2017 and I would be forgiven for thinking I was being ignored. Once again, RTÉ has come to the rescue and will highlight issues that very often are raised here but do not receive much attention. Will the robust monitoring system include monitoring of consultants who are paid but who are not on the specialist register? Are there proposals in that regard? There is a serious issue which I raised with Ms Rosarii Mannion when she appeared before the committee. I asked whether there were people - I do not know if I can use the term "consultant" - who were being paid a consultant's salary and who in the next few weeks or months would find themselves in the legal position of where they would have an entitlement to a contract of indefinite duration. The fact is that there are such individuals. One could not dispute that and it is an ongoing problem. Last night we became aware that in some instances consultants were not where they were supposed to be. It involves a minority of them. Ms Mannion told us that qualified colleagues could oversee the work of those being paid the consultant's rate but that they were not eligible to be entered on the specialist register. It strikes me that there are several holes in the system. If people are in work, they should be doing the work they are supposed to be doing. We see that it happens in a minority of cases. How are the people who are picking up the slack back at the ranch, some of whom are not eligible for entry to the specialist register but who are being paid at the consultant's rate, to be supervised? To be fair to Ms Mannion, she seemed to be hanging all of her hopes on that happening. I would not have any faith in that regard, but it seemed to pass for a strategy in the HSE to deal with what was a very serious issue.

There are a number of competing issues, all of which will need to be monitored. Will the Minister outline how that monitoring will take place and who will be involved in it? When can we expect to see the results published? As someone who represented workers in the health service for many years, I can tell the Minister that if staff in other grades were late for or absent from work, it would not be tolerated. Even if someone was absent from work for a very good reason, he or she would still have to account for himself or herself. I will resist any effort to throw a minority under the bus to deflect attention from this issue because what we saw last night had its origins in Government policy. It is the natural outworking of Government policy.

Deputy Margaret Murphy O'Mahony: I thank the Minister, Mr. Breslin and Ms Casey for coming before the committee. I commend all those involved in devising the plan. I know that many hours of work went into it. It is great that there was cross-party involvement and support. I hope health will always be above party politics and think this is a great start.

I am glad that the Minister referenced the meeting in Cork. As great things happen in Cork, it is a good omen.

The report identifies on page 46 that many people with disabilities are denied access to the

opportunity to live independently owing to the lack of services. The report refers to a statement made by the Disability Federation of Ireland that persons with disabilities are among those at a higher risk of living in poverty. What plans are in place to curb this?

As we all know, most people want to reside in their own home. On page 48 the report deals with the reduction in the number of home help hours and the impact it has having on the elderly and people with disabilities. All Deputies and Senators are inundated with requests from constituents for more home help hours. It is in the top three things being done in my office every day. It is particularly prevalent in west Cork and the issue needs to be addressed. I have spoken to the Minister about it previously. How does he see it being achieved?

I am also concerned about but not surprised by the complexity of the problem in accessing care. It ultimately creates financial barriers for certain individuals, which makes it all the more necessary to ensure health care is universal and available to all. I hope the agreed timeframes will be adhered to and that things will not just be made up as we move forward.

Deputy Simon Harris: I thank Deputies Kelleher, O'Reilly and Murphy O'Mahony for their questions. Deputy Kelleher is correct in that the political system cannot wash its hands and say that all of the challenges relating to the health service have been caused somewhere else. No party, including Fine Gael and Fianna Fáil, or Government can absolve itself from the continuum of change which there has been in terms of policy and which has meant that no project - good, bad or indifferent - has ever been finished. Lots of reform agendas have been commenced but have never been concluded. The greatest strength of the Sláintecare report is the political consensus such that I, as Minister for Health, and my successors will have a roadmap for this area. In that context, I acknowledge the presence of Deputy Shortall, Chairman of that Oireachtas Committee on the Future of Healthcare.

On the enforcement of contracts, I stand over what I said. What we saw on the national airwaves in regard to a minority of consultants was immoral, brazen and unfair. Before we move to the issue of the responsibility of managers, we need to pause and consider that of personal responsibility. We have some very highly-qualified individuals in our health service who did not show up for work or do what they signed up to do. There is a managerial issue here. I refer to the need for accountability and management and for improvements in this regard on a regular basis. However, the managers turned up for work. It was the doctors who, in some cases, did not do so. It is the doctors who, in some cases, did not do what we paid them to do. Deputy Kelleher is correct that it is the job of the HSE to enforce the contracts and the job of the Department to monitor the position and ensure that they are being enforced. I did not design the contract. It is a legacy I have inherited. I do not like the current contract or the current mix of private-public care. I do not think it serves our patients or our public service well. I agree with the direction outlined in the Sláintecare report. Deputy Kelleher is correct in his comments about the impact study. It is important that we check that there are no unintended consequences and that we see it through the prism of ten years. I want it to be clear that I want to see private practice removed from public hospitals, albeit on a phased basis over a number of years. That is my policy position.

Nationally, approximately 82% of the work is being done in the public system. The HSE is reaching or exceeding the 80-20 split nationally in regard to contracts. Within the statistics, however, are hidden outliers on either end. It is acknowledged that some consultants are working way more than they should be and that there is a risk of them being overworked. Equally, there are instances of people working for only a few hours per week and being paid for hours not worked. I assure the committee that my Department has been engaging with the HSE for a

number of months on the need to have a better monitoring system in place to provide assurances that the contracts are being adhered to. I want to see that system in place for 2018.

Deputy O'Reilly asked what the system will look like. I want the HSE to design but I want it to be a system which provides as much assurance as possible in respect of doctors as is the case with nurses. For example, we must know if a person has done what he or she was paid to do. I mentioned that there appeared to be a culture of deference regarding consultants in parts of our health service in that a nurse or health care worker could be asked why he or she was late for work but nobody could actually say whether a consultant had worked his or her required hours. I do not want to cast a slur on all of our doctors because many of them are doing a fine job. However, we know that those who were not doing their work were not, perhaps, pulled up in the same way that other grades in the health service would be.

I do not see this as throwing a minority under the bus. It is appropriate that the HSE would formally investigate each of the cases shown on the national airwaves last night, as would happen in any workplace. I should make the following point because the context is important. The Comptroller and Auditor General's 2015 report on the health service highlighted a problem in respect of the collection of private income such that at a committee meeting at that time we might, perhaps, have been asking different questions, including why managers were not collecting money that was duly owed to the State. It is stated on page 224 of the report that the average delay in collecting moneys due to the State was 186 days. In some hospitals, the delay was more than 300 days. When people talk about setting targets for managers regarding income, that is not in any way to be done in the context of ignoring the legal requirements of a contract. Rather, it is to ensure that moneys owed to the State are collected. That is the situation, for better or worse. Members might want to see that system or the legislation changed but managers are required to collect the money that is owed to the public health service.

Deputy Louise O'Reilly: There is a difference between that and the setting of targets. Nobody is saying that money due to the State should not be collected. Not one person here has said that.

Deputy Simon Harris: I am not suggesting that anybody said it.

Deputy Louise O'Reilly: There is a huge difference between the State obligating its employees to collect money due to it, which is appropriate, and the setting of targets by the State for employees and the stretching of those targets year on year. There is a huge problem in this regard. The Minister cannot say that anybody here suggested that money due to the State should not be collected. Of course, it should be collected.

Deputy Simon Harris: I am not saying Deputy O'Reilly or any other member suggested that. There has been an issue in our health service regarding the non-collection of fees owed to the State. That is not my view or a political view, it was the view of the Comptroller and Auditor General in his 2015 report. It is appropriate, therefore, that, in its service planning every year, the HSE sets out its expectation as to what the revenue level is likely to be and an expectation that managers would bring in that funding. If we, as an Oireachtas, want to change this, that is fair enough.

On capital spending, Deputy Kelleher is correct in the sense that there is clearly huge pent-up demand for capital investment. I welcome that the Sláintecare report examines not only the revenue side of the health service but also the capacity side in terms of capital. We can address this issue through the ten-year capital plan. I say that for a number of reasons. If we decided to

build a number of major new hospitals, ambulatory care centres and so on, there is a significant lead-in time in that regard in the context of planning, tendering, etc. In this regard, a ten-year plan provides more flexibility and scope to the health service. I would not like to interfere in any other ministerial area in terms of the conversations which the Deputy suggests should happen with the European Union regarding fiscal rules and how they are applied to capital. I am satisfied that the ten-year capital plan will provide us with a vehicle for advancement of the bed capacity report, when concluded. As correctly highlighted by Deputy Kelleher, trying to develop a major project with a two, three or four-year envelope is very difficult and not practical. These are projects that require a multi-annual approach. The assurance of funding on an annual basis allows for better planning.

Seven staff in my Department are working on Sláintecare under the direction of a deputy secretary general. The lead executive, when he or she arrives, will head that process. Deputy Kelleher asked about my involvement in this area versus that of the Taoiseach, an issue on which I have previously engaged with the committee. In terms of my understanding of the committee report, it provides that the programme reform office should be accountable to the Minister for Health of the day but also that the office should be under the auspices of the Department of the Taoiseach. Without getting into a definition of the word "auspices", if this office is to be accountable to me, as Minister, and to whoever comes after me, there is a way that needs to work. I want to assure the committee that the Department of the Taoiseach is involved in the steering groups and in the Cabinet sub-committee, which is chaired by the Taoiseach. When the lead executive arrives, we will do all that is required to ensure that the process is robust. We need a whole-of-Government approach to this. I do not dispute that.

In regard to the cancer reform programme, which, as a country, we can and do hold up as a really good example of cancer reform, the lead on this programme worked for the HSE and was not based in the Department of the Taoiseach. We managed to make incredible changes. We should not get too tied up in the physical location of the office, although I accept that people want to know that Sláintecare is supported at a higher level than that of line Minister.

Deputy O'Reilly made the point that we designed the consultants' contract. On the issue of who designed it, I want to be clear that neither I nor the Government designed the consultants' contract position or the public-private mix. I am determined to help us get to a better place in that regard in accordance with Sláintecare. I would not have designed it like this and I am not happy with the public-private mix.

Deputy Louise O'Reilly: The point I was making was that it was politically designed. It did not come from the HSE. I was not trying to personalise it with the Minister. I understand he did not design it. I thought it was obvious but if it was not-----

Deputy Simon Harris: Just in case the public thought I was somehow or other satisfied with the current situation-----

Deputy Louise O'Reilly: I am sure they will do their research.

Deputy Simon Harris: I want to reassure people that this was brought in by a previous Government and a previous Minister. It is not a policy supported by my Government or my party. We will have the Donal de Buitléir impact study and I have outlined what I intend to do in the interim.

On the issue of trauma, I cannot get into it too much because I have not yet brought the

report to the Government. I do not see the need to have a consultation. While I believe it is important, I do not see it in any way stopping or slowing down clinical reforms which are clinician-led. I hope to bring the trauma report to the Government this year when it is published. It will involve significant clinical and patient advocacy buy-in to putting in place a trauma network which will save lives. We will follow the clinical evidence in that regard. I am happy to have a discussion about that.

On how waiting list funding will be expended, while not wishing to frustrate the process, I will have to refer it to the service planning process in terms of the detail of that which will be due out at the end of the year. I look forward to discussing that with the committee.

On the specialist register and the comments made by Rosarii Mannion in that regard, it is important that we do not want to normalise the situation, suggesting we are happy to have people who are not consultants paid as consultants and supervised by consultants. The measure suggested by Ms Mannion was an interim one. We need people to appear on the specialist register and people need to know the consultant they are seeing is a specialist. I will send the committee an update on the state of play in this regard.

I thank Deputy Murphy O'Mahony for her comments on the work done on getting the report together. On the issue of independent living, the detail will be seen in the service plan. The task force on personalised budgeting, overseen by the Minister of State, Deputy Finian McGrath, is due to complete its work this year. We will be able to have fruitful discussions about this in 2018.

Deputy Margaret Murphy O'Mahony: It will be a busy start to the year.

Deputy Simon Harris: It will be a busy year.

It is about how we better empower people with disabilities to make decisions about the allocation of funding that the State provides for them. I agree with Senator Dolan on this and Deputy Murphy O'Mahony is a strong advocate in this area. We must examine how we empower people. For far too long, the State has thought its relationship with the person with a disability begins and ends with writing a cheque for a service provider. We cannot tolerate this. We have many excellent service providers but we need to empower our citizens. Personalised budgeting will provide this. We have received more than 2,600 submissions for the statutory home care scheme. The report on this will be out in early 2018. It is a large consultation. This is what happens when the committee invites me in at the end of the year. This will show the roadmap for a statutory care scheme. I will raise the Deputy's specific issue concerning the service provider in west Cork with HSE.

Senator John Dolan: I welcome the Minister and his officials and thank him for his opening statement. Equally, I note the Chairman's opening statement and welcome it.

New wine in old wineskins comes to mind. Deputy Billy Kelleher talked about perverse incentives. I am not being prophetic in saying that is what is happening. It is an absolute risk and danger, however. This report is wholesome and we are all committed to it. It is important, however, that it does not catch the old viruses in the system. That has to be watched morning, noon and night.

If one takes the broad family of people with disabilities and issues such as mental health and chronic conditions when they get to a certain point, it involves a minority of the population. However, it is the majority of those who face into the health system regularly and need support

from it. We have the recent information from the Central Statistics Office, CSO, on the 2016 census. Compared to the 2011 census, the population of people with disabilities is up from 13% to 13.5%. The number of young people with disabilities has increased. Hopefully, they will have many years of life. However, it is years of living life with a disability. It is different from becoming disabled when one is 70. There is the good story there that people are able to survive and get on. Up to one third of older people have a disability.

I am concerned when I hear those involved in service delivery saying they do not have supports. Recently, I heard someone say they could not give a person with a disability support because they are waiting for someone who has the support not to need it any more. That is the case as we go into the fifth year after the recession. I am not pointing the finger at anyone but we are not able to keep pace with the level of need and expectation.

The Minister stated earlier that the report strongly supports a shift in our model of care, moving away from a hospital-centric approach to one focused on prevention, early intervention and providing the majority of care in the community. I absolutely agree with this. There was also reference to the human resources and staff in the system. Staff are an element of the human resources but not the total, however. The person with the disability or an illness is a resource. Their family, as well as the numerous voluntary and local support organisations, are also a resource. We also have 200,000 carers. There are more full-time carers than nurses in our system. These are real facts. A new approach has to look at the broader human resources issue and how we support those who are disabled and others.

There are outside resources such as the environment and the social determinants of health, as well as the rightfully growing expectations people have. I first saw that graphic about social determinants of health in the 1994 health strategy. If it was not in that one, it was in the 2001 strategy.

Mr. Jim Breslin: It was in the 1987 strategy.

Senator John Dolan: We should not go back that far. Mr. Breslin must have read that in a history book.

Naming the condition does not cure it and naming the possibilities does not make them necessarily happen. The Minister's presence was spoken about. There is also the presence of other members of the Government, whether here or in addressing this issue. Poverty is a massive issue. Unemployment is a massive issue. There is also poor nutrition, isolation and poor living conditions. There is a real place in all of this, if one wants to get to prevention and early implementation, for other members who sit around the Cabinet table, which must happen more often. That is the axis on which the implementation of this report will move in the medium and long term.

Earlier the Minister mentioned he was frustrated with the pace of the report's implementation and that it was a ten-year report. The Secretary General mentioned 1987 and I mentioned 1994. We had the Health Act in 1970 that resulted in eight health boards being created. There was a change in 2000 that reduced the number of board members to seven plus the Eastern Regional Health Authority that had four subsets. Four years later we got the Health Service Executive. I have lost track of all of the reforms and changes of structure in the HSE. We had a governance structure and we lost a board. There were supposed to be other changes but they have not happened and now we are going back to a board. We must move beyond simply changing the governance charter because there is more to reform than that. Part of it is drawing

in other members of the Cabinet. We must also analyse the things that happen outside of the Department of Health that have a huge impact on people's lives. As I have said before, children have got through school, graduated from college and face the hurdle of finding employment. That is a tipping point for them in terms of their health and well-being. If they can move on their health and well-being will be in a way better space. If they cannot then they are back in some day place. What does that do for someone who is in their mid-20s, 30s or, indeed, 40s?

I wish to refer to three aspects of the implementation mechanism. One can get the right man or woman but the system that he or she works in will help or hinder.

In terms of legislation, the Minister has mentioned putting administrative programmes on a statutory basis and gave a commitment to do so. However, there is a dysfunction between the fair deal scheme and the plethora of instruments that are required to keep a person in his or her home and community. The requirements range from personal assistants, home supports and access to other services. Resources are an issue in the health services and beyond.

Another aspect is the organisational and cultural change. Cultural change must include a whole of government approach but it must also be about the public understanding of what our health services are trying to do. We have a way to go with that because we tend to think of our health services as being there to fix us. We need the fixing bit but we also need health services and supports to live well.

In conclusion, I shall mention the empowerment of people with disabilities. The mobility allowance was abolished almost five years ago and the anniversary will be at the end of next February. Ironically, the allowance was abolished due to equality issues and replaced with the motorised transport grant. The mobility allowance was introduced in 1979. People now use new language about empowerment and claim money follows the person. What was the mobility allowance? It was an outstanding example of putting a few bob in someone's pocket to help him or her with his or her mobility. It was money follows person and it was the person maximising his or her choice. Therefore, we must rethink the current initiative. Thirty years later people talk about the principle of money follows the person. The mobility allowance was a simple programme that gave a few bob to people in west Clare, Donegal, Tipperary and wherever. I am not having a go at the Minister but simply making a point. As I have pointed out before, young people with disabilities have been put into nursing homes without consideration being given to other options while at the same time we are trying to move disabled people out of institutions. Having the correct mindset, and dealing with the soft stuff and cultural aspects are very critical to making Sláintecare work.

Finally, like others, I welcome Deputy Róisín Shortall who is chair of the Sláintecare group.

Senator Colm Burke: I thank the Minister for his presentation. He referred to €25 million for primary care during his presentation. One of the issues in relation to any health report and change is about focusing on the primary care setting. At present a huge amount of work is being referred to hospitals and GPs claim, and rightly so, that they do not get enough support. I am concerned about the ongoing GP contract negotiations because they seem to be lasting a while. I presume contract negotiations must take into account the recommendations in the Sláintecare report on how we should progress.

I recently travelled to Plymouth with the National Association of General Practitioners and visited a number of GP practices. One of the practices was very pleased that the time patients had to wait to see a doctor had been reduced from 15 days to eight. On our visit we also discov-

ered that all of the doctors who worked for a large GP practice of over 20,000 patients handed in their contracts and walked away. As a result a local hospital had to recruit GPs to fill the void. I do not want such a scenario to happen here in Ireland. Therefore, it is extremely important that we progress and develop primary care. We must ensure we adopt a joint approach rather than being dictated to from the top down.

I would like the Minister to indicate the current state of the negotiations and the timeframe involved for the GP contract. Let us remember that the last contract is over 40 years old so there is a need for constant review. The contract is a fundamental part of our health service. As the chairperson mentioned in her opening statement, we cannot leave the negotiations to continue *ad infinitum*. I had the privilege of serving on a State board for ten years. I was involved in the contract negotiations for one particular aspect but, unfortunately, it took us 11 years to make progress. I understand that the negotiations for the last consultant contract between the HSE and the Department took between eight and ten years. Can the Minister tell us the current status of the GP contracts, the timescale and targets? I know he cannot be very precise as negotiations are ongoing but we need some indication on that issue.

I have expressed my personal concerns about the following matter to the Minister over the past six months. On the one hand, we are talking about a major ten-year plan. On the other hand, there seems to have been a free for all in terms of hiring staff for the HSE. More than 2,000 additional people have been hired in administration and management between December 2014 and April 2017. Over the same period only 39 additional public health nurses were employed. That leads me to the issue of management, an issue that arose in respect of the RTÉ report last night. My colleague raised the matter of specialist registrars not having the qualification but being paid as consultants. Have we clear qualifying criteria for the people we install in management in hospitals? I am aware of one hospital, and I have raised this with the Minister, that is now on its tenth manager in 18 years. There appears to be a constant roll over of responsibilities within the HSE whereby one is in a position for two years and then one moves on to another job. When the new person arrives, he or she can say he or she was not in that position when a decision was taken. There is a delay in the decision-making process as well because the new person in the position has to familiarise himself or herself with the issue involved and can find that he or she is making no progress.

I am aware of a case recently where a GP came forward with a comprehensive proposal for cutting the cost of a particular service for the HSE. However, he threw in the towel after 18 months because every time he went to meet somebody from the HSE to discuss it, a different person arrived and nobody could make up their mind. This was about a saving whereby GPs would provide an additional service at a far reduced cost compared with the cost of people having to go to hospital. That is an issue we also must examine when considering reform in the health service. People are going into positions but the situation does not change after six or 12 months, so when somebody new arrives the person can say he or she was not there when something happened. That is happening in the health service as well when there is a change in Ministers. That culture appears to have transferred down the line. It is a problem we must resolve. When dealing with the management issue we must have a proper structure for dealing with that aspect as well.

Deputy Bernard J. Durkan: We have spoken repeatedly about a number of issues. The Sláintecare report is an integral part of policy. It has been adopted by the Department and now must be implemented. We all accept that. Anybody who has spent time in a Department will readily acknowledge that timescales are very difficult to fulfil. If we think that one simply turns

over a new page and overnight we will have a new system that will be effective, responsive and accountable, we are kidding ourselves. It does not work that way and never has. There are repeated examples of that.

The Secretary General referred to the 1980s but I can refer back to the 1970s when we had a system-----

Chairman: Please do not.

Deputy Bernard J. Durkan: I wish to compliment RTÉ. It has been able to raise a number of issues recently from the outside which should have been readily visible and within the reach of the Minister and the Department at all times. We should not have to wait for a report from anywhere. That is my criticism. Over the past few years, I have repeatedly pointed to the unworkability of the system we have. I realise that we are going to change and renew the board, but I will return to that shortly. The fact is that the system does not work and can never work. I repeatedly drew attention to that during the discussions on the Sláintecare report. If people think that it will work, they will find out ten years hence that it does not.

I read some of the reports that were produced prior to the abolition of the health boards in 2003 and 2004. Some of the professionals felt it was necessary to get rid of politicians from the boards because they believed they should not be there at all. Public representatives were a bad thing and one could not have them there making such decisions. They were stopping old hospitals in the country being closed and the like. However, we know now that their removal from the structure did not solve the problem. There must be accountability and public representation. On any board there must be the professionals at the centre and public representatives. The three groups, including the hospitals, are merged and then the services are delivered. We are kidding ourselves if we think for a moment that we can superimpose the Sláintecare report on the existing system and achieve a good system. Many members do not agree with me but I believe that the board should be broken up into at least four boards, whereby regional views would be heard at the centre. The people on those boards should also be on a national board. I have spoken about this previously.

I have also spoken about the snags that trip up the system, why the system does not work and why the river does not flow smoothly. We have discussed this in the committee repeatedly yet, lo and behold, RTÉ can produce an investigative report that points to some of the snags in the system. They will remain there for as long as it takes to suffocate the system. There is an urgent need to find out where those snags and barbs are, why the system does not flow smoothly and why people find themselves waiting forever. There would be no need for waiting if we identified those issues. I am aware from my dealings on this in my humble, simple way, because I am not an expert on this business, that countless people on waiting lists are being recirculated again and again within the system. They are in the system or on a list three or four times. There is no necessity for that. They must be dealt with on a once-off basis to eliminate that part of the problem. That is another issue on which RTÉ or somebody else could conduct an investigation as well, to find out what is happening in that regard.

I have spoken to consultants in the public system who are frustrated. I have mentioned this previously. They find that a day in the public system compared with a day in the private system is like comparing chalk with cheese. The reason is that they can get a full day's work done in the private system, because it is too costly to leave theatres and staff idle when people do not turn up for work or whatever the case may be. The private system cannot afford that. However, for some unknown reason that happens in the public system. There is a budget of over €15

billion. While it is not the biggest expenditure ever, it is quite formidable given the size of our population and the size of the service. It is a wake up call to find out whether we target our money to the areas where it should be targeted and whether we get good value for it. Effectiveness comes with efficiency and good value. If we are not effective, we are not dealing with the problems and we will have to deal with the same problems in 20 years' time.

I believe we must show progress in this area. We are all on trial on this issue. This winter is a litmus test of the system as it stands and the extra money being provided. If it does not show results there is a far more serious problem, and pouring more money on it will not solve it. I hope we do not find ourselves three or four months hence looking back and finding that although we spent more money, we did not get a better return. Take the example of the scoliosis cases. Why in that situation was there such a severe problem affecting a relatively small group of people in terms of the overall numbers that could not be resolved? It does not require rocket science to figure it out. The problem was small but it was huge for the individual patients concerned. It has a huge impact on their and their families' lives. We must examine that as well.

I have said enough. The setting of targets is fine. We must set targets and they must be ambitious, but we should never attempt to set targets based on insecure, unsafe and unworkable structures. If we do that, we will only repeat the mistakes of the past. I read the speeches of the Minister at the time the health boards were abolished with regard to the intent behind abolishing those boards. Nothing has changed. During the years that have elapsed since 2003, we had a major recession. That was not a help, either. The fact is that we now have to stand back.

Incidentally, accountability seems to have been lost. Between 2004 and 2012, there was no accountability whatsoever as far as public representatives or committees of this House were concerned. We could not even get answers to parliamentary questions. That was forbidden and the system was all closed off. I stand testament to this because I objected strongly at the time. I did not wait until now to do so. I was punished severely for it on numerous occasions in the House. If I get angry when I hear some of these things repeated over and over, it is with just cause. I hope we have learned some lessons and become realistic in our outlook. I hope we do not repeat the mistakes of the past by depending on structures that have been shown to have failed. I also hope that, by identifying those unsound structures, we will build a new health system on a sound basis that is accountable, efficient, cost-effective and as good as any comparable service in Europe or elsewhere.

Chairman: I invite the Minister to respond to the questions from Senators Dolan and Colm Burke and Deputy Durkan.

Deputy Simon Harris: I will take the questions in reverse order while they are fresh in my mind. On Deputy Durkan's comments, I think those of us in the political system may ask if there are people in the Civil Service who are committed to health reform. However, if we are to be honest, those in the Civil Service might also ask if those politicians are ever committed to health reform. I do not think Ireland Inc., the political establishment or the Civil Service have covered themselves in glory in terms of starting a reform process. There has been stopping, starting and changing. I certainly am aware of the level of confusion there has been in my Department in respect of health policy for a significant period. None of us can be fully absolved of blame in this regard. There is a great level of enthusiasm right through the Department now that there is a roadmap and also a plan that is not going to keep changing. We can actually get on with a body of work now, which is quite encouraging.

I take the Deputy's point about public representation. It should not be seen as a dirty word.

People are elected to represent the citizens and have a right to stand up for their communities and constituencies. I think 8,000 parliamentary questions were asked of my Department last year. Certainly, the volume of issues Deputies are highlighting is quite immense.

I feel strongly about reinstating the board of the HSE. I spoke very strongly about that matter before the Sláintecare committee. I do not think it is appropriate that a CEO is effectively reporting to himself. I do not mean that about the individual CEO because I have heard that director general say the same thing publicly as well. We cannot have a situation whereby people meet and tell each other whether they are doing a good job or a bad one. In fairness, it was an interim arrangement because it was meant to be about dismantling the HSE. We now have the Sláintecare report and need to embrace the fact that there is going to be a national entity, albeit with much devolved to the regional structure. It is clearly stated on page 26 of the report that this is a move towards a form of regional health resource allocation with accompanying governance structures. There are some things that will always be done better on a national level. We would not have delivered a national cancer strategy that is saving thousands of lives if we had taken a fragmented approach. We would not have delivered some of the clinical programmes in respect of sepsis. Lots of progress has been made on the basis of operating at national level. Nonetheless, far too much has been centralised and is done at that level. There are often too many layers between the patient and the solution. The HSE, as currently configured, is not the vehicle of the future. The Deputy is entirely correct in that if we were to take the policy elements of Sláintecare and impose them on the current structures, we would not fix the health service. In fairness, the report does not propose that we do so but, rather, that we make significant changes.

The point about the budget is accurate. I can have an old and broken car and even if I spend an awful lot of money on repairs, it will still be old and broken. It is right and proper that we increase investment in the health service but the car we are driving needs to change. It is not sustainable to keep pouring money into the current model. Change and reform are not things that are nice to do for the sake of it, discretionary extras or things that we are all doing because we think we are supposed to. We actually have to do them. The system is falling over and we have to put in place a better health service.

In the context of this winter, the HSE publishes trolley figures every day at 8 a.m. They are there for all to view and show that there were 1,300 fewer patients on hospital trolleys this November than last November and, overall, fewer patients on trolleys every day this November than last November. However, there are still far too many patients on trolleys. We cannot pretend to be surprised when we have not linked demographics to health services. I often use the example of education. One would be envious of the Minister for Education and Skills. That Department does not always get it right but, broadly speaking, every year it knows that there will be X children turning four, five or six and that Y number of schools, teachers, desks and so on will be required as a result. With, I accept, a few bumps in the road, it generally matches. We have not done that in the health service. That is what the Sláintecare report, the bed capacity report, the capital plan and the GP contracts are all about. It has to be demographically linked from now on and I want to assure members that it will be.

Senator Colm Burke referred to primary care. There are things we can do quickly to show a shift to primary care and make a real difference. There is the big stuff and the ten-year plan but there are things we can and should do next year. I was in Castlebar at the opening of the primary care centre, which Senator Rose Conway-Walsh attended. There were 517 people in April in Mayo waiting for an X-ray. They opened a primary care centre and put in an X-ray

facility. There is an ultrasound facility going in now also and there are zero people waiting for an X-ray in Mayo. We are going to do one in Tuam. There are straightforward things. A very good example is the primary care eye review. Dr. Billy Power as clinical lead and others came together. Ophthalmologists in the community and acute hospital settings have spoken. At relatively small cost, they can shift an awful lot of procedures and review appointments out of the hospitals. We can do that. We should be able to start that in a real way next year. There are things we can do quickly.

There are other things that are going to take a little bit longer. This is where there is friction, which is recognised by the committee and the report, between building capacity and increasing the service. We have to be sure we get that right. I take the Senator's point that we do not want to lose what is good about our GP service. Recently, I launched the report by Professor Tom O'Dowd of Trinity, which showed that about 90% of Irish citizens are very happy with the GP service they get. They would like more and all that stuff but they are very happy. That will not come as a surprise or shock to any public representative or citizen. However, we do not want to end up with a waiting list for GPs. That is part of the Senator's point. When I tried to articulate that recently at the launch of the report, it got completely distorted by a GP organisation, which tried to say that I was making an outrageous point. I will restate the point I made now and on every occasion I am asked. It is that there are parents who go to bed worried about finding €55 or €60 to go to the doctor the next day. Regardless of whether GP organisations like me saying that, I am going to keep saying it. It is not acceptable. There is not just an equity of access issue in secondary care. There is an equity of access issue in primary care. Does that mean everything has to be absolutely free? I do not believe so. The Sláintecare report refers to "no cost or low cost" and there will be different things for different services. The point I was trying to make was that we need to have that discussion. It is not about competition authorities or setting fees. It is interesting that they said the Minster is interfering. People usually call on me to interfere in absolutely everything but when I dare to say something about €55 or €60 being too much for a lot of working families that do not qualify for a medical card, I am criticised. That does not mean it has to be entirely free. We should listen to GP organisations about the lessons from the provision for children under six, which are significant.

The Senator asked where we are with the contract in respect of the Financial Emergency Measures in the Public Interest, FEMPI, Act 2015. We have made good progress with the Government decision of two weeks ago. The Chairman has rightly raised this matter with me before on behalf of constituents. The issue has also been highlighted by organisations. We have a process to unwind FEMPI for public servants. People working in the health service today will start to get some of their FEMPI money back over a period. They have agreed to do different things as a result of that and the process is in train and has been accepted by all health unions. The health contractors had FEMPI and have not had a process of restoration. Our GPs have taken huge hits. At the event to which I just referred - although it was not reported - I also said that GPs have been put to the pin of their collar in many cases. They are under huge financial pressure. I acknowledge that. We have a process now whereby we can engage with GPs very early in 2018 in respect of FEMPI. I describe that process as an enabler for some of the changes we need to make to primary care.

The Senator asked where exactly we are with the contract discussions now. He is right that it is a very old document that we are working off and there is a huge amount of work to be done. We now have a very clear list of all of the issues and all of the things we could do in primary care services. There are some things GPs want to do, while there are others we want them to do. We have that list and are working our way through the issues. I hope we can make some

progress on it in 2018 in order that we can provide some additional services. The Budget Statement of the Minister for Finance, Deputy Paschal Donohoe, was instructive in its references to the need for a multi-annual approach. I was pleased when the Minister talked about the need for multi-annual investment in primary care services and the GP contract. The inclusion of that line in the Budget Statement should be seen as significant.

On the point made about administrators and managers, while I do not want to go back over conversations we have had previously or repeat information Ms Mannion has provided for the committee, it is important that we make sure everyone is on board for Sláintecare. We cannot have a situation where there is a different reform programme or process in the HSE from that in the Department or across government. Last week I chaired a meeting of the HSE leadership team and the Department's management team. We had a very good meeting and I felt there was a buy-in by both organisations. My aim was to deliver a clear message that there would be one plan and that was it. Once it is in place at the end of the year, whether someone is in the HSE or the Department, that will be the plan to which he or she will work. All decisions need to stem from it and not from a different reform agenda. There is room for only one ten-year plan. We can address a lot of the issues when we have the plan, but it will be the plan to which the HSE will have to work in the decisions it will make.

At one level the point about management turnover is valid. Deputy Louise O'Reilly often reminds me that it is difficult to make international comparisons at times, but I make the point that in the NHS there is probably a greater turnover of managers. Managers stay for significantly shorter periods in the NHS. That is what I am being told.

Senator Colm Burke: I would not use the NHS as the template.

Deputy Simon Harris: I would not either, but a lot of people in this country hold up the NHS as marking the point to which we want to get. In that context, I make the point that there is a significant turnover of managers in the NHS. We are in a situation where we need to develop management within the health service and hospitals. I sometimes get into trouble for saying this, but the truth is that where there are good management structures in place in hospitals, we perform better than where we do not. I was in one the other day which shall remain nameless. There had been a change in a number of personnel and there was a lot of new energy in the place and the metrics were very much moving in the right direction. We need to support good management. We also need to recruit good managers. We need to consider holdindg more international competitions. We recently hired two deputy director generals for the HSE through an open international competition.

I thank Senator John Dolan for his comments on other members of the Government having a role in this regard, which they do. A lot of what is contained in the Sláintecare report and what the Senator talked about is preventative. It is concerned with having a healthy society and people not getting sick in the first place. I have a role to play in that regard but so too does education, as well as a lot of elements of the health service. Issues such as poverty are also relevant. The Senator's advice is wise in avoiding what he described as old viruses in the system. This is not the first time people have tried to reform the health service, but this time there are differences. The all-party approach is a big one. I also take the Senator's point about going beyond structural change, which is also a risk. If in a year's time the public sees that all we are doing is talking about structural change, the view will be "here they go again." I believe structures need to be changed for all of the reasons outlined by the Sláintecare committee. There is too much centralisation; there is no proper governance and there are lots of changes we have to make. However, in doing so we also have to try to have tangible wins for the people in order

that they can see the benefits.

Chairman: I thank the Minister. The last three contributors will be Deputy Joan Collins, Senator Rose Conway-Walsh and Deputy Róisín Shortall.

Deputy Joan Collins: I do not want to go over old ground, but we know that we have a very dysfunctional health system. The NHS in Britain was set up by Aneurin Bevan and there was a structure to which everybody worked. In Ireland the system was developed in a completely different way. We have section 38 and section 39 organisations, the involvement of the religious in health care, private GP services and so forth. The Sláintecare plan is very significant because, as the Minister has pointed out, it provides a roadmap for us. Everything one discusses, no matter where someone is in the health system, will be guided by the plan. It is radical and one that I support because it will move us towards a single-tier, universal health service paid for from general taxation. However, I am concerned because the report was laid before the Dáil on 21 May and we were supposed to have quarterly reports on the implementation of the plan, which means that we should have received such a report in September. We had a debate on the report which began in the Dáil on 22 June and only finished last week. We have had a very poor response from the main political parties. There has been only one speaker from Fine Gael and two from Fianna Fáil. That is an indicator of a lack of interest, which gives cause for concern.

The real driver of the programme is the setting up of the implementation office and the appointment of an implementation officer at Secretary General level. That should have been done by July. While I accept that delays can happen, progress is very slow. The Minister has said that in July the Government agreed to move forward with the establishment of a dedicated programme office and to recruit a lead executive, but we are still waiting for that to happen. We recommended that the office be located within the Taoiseach's Department. The Minister made reference to the technicalities involved and said it would be located within the HSE. However, if there is resistance, that is from where it will come. Locating the office in the Department of the Taoiseach was recommended in order that it could be kept separate. The idea was that the lead executive would have authority to implement the plan.

The Minister has said he has also been tasked with developing a response and a draft implementation plan for consideration by the Government by the end of the year. The committee did not ask the Minister to do this. We asked that the implementation office do so, in co-operation with the Department. That is why it was so important that the implementation office would be in place as quickly as possible in order to direct progress. The issue of private practice in public hospitals, for example, should have been dealt with by the implementation office, in conjunction with the Departments of Health and Finance. The implementation office will be the driving force and unless it is put in place, implementation of the plan will be left up to the Minister, which should not be the case.

The Minister has said €1 million has been set aside for the implementation office, but we wanted much more to drive it forward. We wanted someone to take the Sláintecare report and figure out how to get a buy-in by staff, the general public and all of the political parties. There have been countless reports produced on the health service. It has been pointed out that 2,000 administrative and managerial staff were recruited between 2014 and 2017, but only 39 public health nurses were recruited in the same period. That is what the implementation office is supposed to address. If there are proposals to recruit new public health nurses, we must go into the schools to encourage young people to consider working in the health service. We need to tell them that it will be vibrant, not the service that is in place, that in the future those who will

work in it will enjoy their work. We need to improve communications between staff - nurses, doctors, GPs, psychiatrists and so forth. Unless there is a vision driven by an implementation office that will be absolutely determined to achieve the Sláintecare reports goals and that will work with all groups of stakeholders, we will not succeed. The implementation office will not be able to cover every dot and comma, but it can work with the groups affected and convince them that if they work with it, there will be change. However, it must be funded properly to enable that to happen. Allocation of the €600 million required for the Sláintecare plan has not been committed to in the 2018 budget.

There are many things about which I am concerned and unhappy. Unless there is urgency in addressing these concerns, the people in the background who do not want them to be addressed will just keep picking away and undermining the process and we will not have a health service of which the people can be proud and in which they can proudly work.

Senator Rose Conway-Walsh: I thank the Minister. I commend the great work done in bringing to fruition the new primary care centre in Castlebar. It is fantastic. However, it is 17 years late. One of the pilot projects under the original primary care strategy was in County Mayo. However, the projects were never invested in or developed in the way envisaged. Seventeen years later we have the centre in Castlebar which we do welcome.

What worries me a little is that when the Minister goes to some of the primary care centres, he gets all of the good news and hears examples of good practice, rightly so. That is appropriate as it is important to mainstream good practice mentioned to the Minister in all of his visits, but he is not necessarily told that there are hundreds of children in County Mayo, for example, waiting for physiotherapy. People wait for physiotherapy throughout life because we do not have nearly enough physiotherapists or occupational therapists. Bearing in mind the needs associated with long-term illness and maternity care, for example, this issue is not being addressed in a proper way. Sometimes it can be covered up. This speaks to the number of parliamentary questions the Minister is being asked. That they have to be asked in the first place is a waste of resources. There are many things being covered up that should be transparent.

I wish to concentrate a little on the programme on the HSE shown last night. It begs the question as to whether RTÉ is responsible for running the health service. We owe a debt to people such as Ms Oonagh Smyth and others who bring these concerns to the fore. It is extremely worrying that 43,500 public patients have been displaced because of what is happening within the system. Private patients are receiving preference over them and those affected have lost out in the past two years.

What has been lost as a result of the 2008 contracts not being fulfilled? Has the Department estimated the cost to the public system? Are there sanctions to be implemented? Have they ever been implemented against the consultants who clearly broke their contracts? If we do not have sanctions, we will not produce the behaviour required. Was the Minister surprised by last night's programme or did he have all of the information already? Why did the HSE stop compiling the compliance data for private practice limits within public hospitals? Did it ask the Minister for permission to do this? Sometimes it is very difficult for people to know what the relationship is between the HSE, the Minister and the Department and where responsibility lies. It seems that the Minister has all of the responsibility and that the HSE has all of the authority in terms of implementation. Did the Minister stop the compilation of data in 2014?

The strategy is very good. The Minister's way of encompassing all political parties, albeit with limitations, is good. It gives me some confidence. I must, however, look back to 2002

when Fianna Fáil was following its ten-year strategy, the aim of which was to deliver high quality health care for all. The distinction between the public and private systems, however, was still to remain under its strategy, but it stated there would be greater equity for public patients and that this would be sought in the revised contract to come about in 2008. The current strategy, like the Fianna Fáil strategy which was an absolute failure, no more than A Vision for Change which was never supported or implemented in the way it should have been, will be judged by the hundreds of thousands waiting for appointments, those waiting for physiotherapy and occupational therapy in County Mayo and those waiting months for counselling, the waiting period for which is very worrying. If a young person in County Mayo presents for counselling today through the primary care counselling system, he or she may have to wait for many months. I have experience of working with it all the time on the ground.

I welcome the allocation in the budget for extra home help hours. However, the Minister will know that it was only to address part of the existing waiting list. It is not a matter of home help care hours anymore but home help care minutes, which is wrong. If the Minister was to underpin the strategy and take immediate action, even by addressing the issue of home care minutes by offering a minimum period of one hour, it would solve many of the problems. People could be assured of having one hour rather than minutes. There are other practical steps that could be taken in the meantime.

I wonder how much it cost to devise the Saolta system, even in terms of branding and logos. Does the Minister have a figure for it?

Education and training are key to tackling these issues in the longer term. There are models of good practice elsewhere. What relationship does the Minister have with the Department of Education and Skills? There are young people I know who would make fantastic doctors but who cannot obtain the points required or get through the quagmire of barriers they face in the education system. I would like to see some movement in that regard. We absolutely need to see it. There could be a relationship whereby, even through funding models, a young person would be compelled to work within the Irish system for a certain number of years. Until we tackle this issue, we will continue to have problems. In all of this, I am conscious of the challenges that arise in the recruitment of clinicians across the board.

I would appreciate it if the Minister answered those few questions.

Deputy Róisín Shortall: I apologise for being late, but I was watching the proceedings on the monitor. I welcome the Minister's presentation and his very positive comments on Sláintecare.

I agree wholeheartedly with all of the Chairman's comments on concerns we all have about the slippage of the plan in its timescale. The starting point is the implementation plan. We have all been of the view that this is key. The lead was supposed to have been recruited in July. While there was slippage because of the change of personnel in government, I was very hopeful when I spoke to the Taoiseach in August because he said he was engaging in the recruitment process that month. Unfortunately, four months later, we are still being told that the recruitment process is about to start shortly. I would like the Minister to clarify whether there is to be a public recruitment process or whether he is headhunting. Where exactly are we in the process?

I endorse the comments made by Deputy Joan Collins on what the Sláintecare report set out regarding implementation. On page 135 it outlines the steps that need to be taken. It states: "These provide the big-picture blueprint for a project plan to be developed by the Programme

Implementation Office as one of its first actions and against which the implementation effort will be measured." With all due respect to the very fine people in the Department of Health, there is institutional resistance to change in any major organisation. This was supposed to be a detailed plan devised by the implementation office, not devised by the Department of Health. If the Department or the HSE were committed to change, we would have seen it long ago. We have not seen that kind of change, however. I do not discount the key role the political system plays in this either. It is a very important point that we should be recruiting an experienced person to lead and allow him or her to recruit a team and devise the detailed implementation plan. It is regrettable that it has not happened. The absolute urgency is to recruit that lead person. I hope there will be no further delay. I have received the same reply every month for the last four months on this and we would like clarification and action at this stage.

There is no doubt that there is a price tag attached to the health programme. The timescale of 15 years which had been proposed was completely unrealistic. The committee took the view that we should be spending to save. There is no doubt that ehealth would achieve considerable efficiencies and safety within the system and we reckon it should be implemented over a five-year period. While it is welcome that funding has doubled, the roll-out is not being accelerated sufficiently and certainly not in line with what has been recommended.

The Minister referred to progress on the impact study in respect of one of the key recommendations, which was to disentangle public and private medicine. This goes to the very heart of the problems within our health system. Coming to the end of the process, a number of members of the Committee on the Future of Healthcare came under severe pressure from outside to try to water this down or scrap the idea. There was a push to qualify it to some extent in calling for an impact assessment to be carried out. The final agreement on the wording was that there would be an impact assessment to assess the impact on public patients. That is because we do not want this process used as an excuse to hold up the disentangling of public and private medicine. That is what it looks like at the moment and I have a serious concern about it. We need to move swiftly to start that disentanglement. The vested interests that have maintained this very odd hybrid, which is unheard of anywhere else, are those people who are benefiting from the system as it operates at the moment. They are not acting in patients' interests.

This brings us to the revelations in last night's RTE "Prime Time Investigates" programme. There is a 2008 contract covering all consultants. Last night's programme found that a significant minority of consultants are not adhering to it. That is for two reasons. A number of consultants are going off site to spend more time doing private work than public work and they are not meeting their public hours commitments. Others are doing an undue amount of private work in public hospitals. The contract provides for 39 hours of public work. It is an extraordinary indictment of the system that no one knows whether consultants are doing 39 hours. We know plenty of consultants exceed those hours but those committed people are being very seriously traduced by the behaviour of those colleagues who are engaging in the gaming of the system which we saw last night. The fundamental issue is that the Department of Health and the HSE have no idea whether the contract is being complied with. This affects nearly 2,500 consultants, all of whom are handsomely paid by the public purse, but we have no idea whether they are doing their work. It takes "Prime Time" to put a number of those consultants under surveillance to find out what the truth of what is happening is. That is a serious indictment of the system.

We need the urgent implementation of the contract. A number of issues arise in that regard. The new contract provided for the appointment of a large number of clinical directors. These are consultants who were given the task of supervising their colleagues, for which they are

paid an additional €46,000. What on earth are those people doing? Clearly, they are not doing their jobs. Is it time to sack some of those clinical directors or, at minimum, withdraw the huge €46,000 allowance they receive for work they are clearly not doing? What about the common waiting list? That is part of the contract. Is there a common waiting list in operation in any public hospital? These are the clear legal terms of the contract but they are not being enforced. What about penalties for consultants who breach the 20% limit? The arrangement was that they would repay the income they received from private practice. In the early days of the contract, we got some figures on the extent of the breaching of the limit and what those consultants owed. I am not sure any of that money was collected. Certainly, the Comptroller and Auditor General drew attention to the problem. That is part of the legal contract. Why are the Department and the HSE not enforcing it? Senator Conway-Walsh asked why the Department stopped collecting data which would have let us know what was actually happening. Why is that?

The Comptroller and Auditor General drew attention to the following a couple of years ago. In 2015, Mr. Tony O'Brien stated in a confidential email to the then Minister for Health, Deputy Leo Varadkar, that the 80%:20% split was a farce in practice. What did the then Minister do about that? Before the Committee of Public Accounts in 2015, Mr. Tony O'Brien referred to the private sector as having a parasitic relationship with the public sector. He said the information he had was that approximately 56% of admitting consultants in St. Vincent's private hospital were consultants whose contracts did not permit them to work there. We were to get an audit of all of that but we have not seen the results. Why has there been a two year delay in getting to the bottom of that when the evidence shows widespread breaches of the contract? We have a vastly expensive contract with approximately 2,500 consultants which is clearly being breached all over the place. That needs to be pursued rigorously. What exactly is the Minister going to do about that? The responsibility lies with the Department and the Minister to ensure we get value for money, which, clearly, we are not. The people paying the price for this are the 685,000 people on hospital waiting lists.

The NTPF was asked to carry out an audit two weeks ago of waiting lists in five hospitals. It found that the current waiting list situation was shambolic with widespread queue jumping and a failure to follow any of the protocols. The current waiting lists have no integrity. However, there was a big gap in the information provided, although I am sure the NTPF has it. We need to see it published. I refer to the profile of those people who are skipping the queue. The suspicion is that a large number of the people the NTPF found going directly onto waiting lists for procedures were not coming through outpatient departments. There is a suspicion that people are forking out €220 to see a consultant and then finding their way onto a list within the hospital and receiving their treatment earlier. We need to carry out that profiling of those people who are skipping the queue. Many of us have suspicions about it.

I refer to the NTPF and the initiative taken this year and last year which Fianna Fáil supports very strongly. It is great to see people moving off the waiting list but if the Government takes an approach of incentivising a slowing down of work progressing through the public lists, it would create yet another perverse incentive for consultants to go slow when they could then be paid on the double if people access treatment by way of the National Treatment Purchase Fund. That is a knee-jerk reaction and response to a problem; it is not a sustainable position.

This is not the Minister's policy with respect to the 2008 contract, but it is the previous Government's policy of allowing public hospitals to breach the 20% limit of work. I recall that situation arising where a decision was taken at ministerial level to lift the cap on the amount of private work that could be done in public hospitals. That immediately created a perverse

incentive for hospitals which are already strapped for cash to increase the number of private patients. As other speakers have said, the fact that hospitals were given stretched targets only exacerbated that. Hospitals were incentivised to take more and more private patients at the expense of public patients. That is a policy for which Fine Gael, under the previous Government, is responsible, and it must be tackled.

Ultimately, we need a new consultant contract that will be a meaningful one and that will give us value for money and treatment for public patients. All people should have the right to access treatment as public patients. That is what a good quality universal public health service is about but in the meantime the Minister needs to give us an assurance and set out a clear plan of action to rigorously enforce the existing contracts that are in place, and where people have been found to fail in that regard, action should be taken. They need to be made accountable.

Deputy Joan Collins: Before the Minister replies, I wish to ask him about the legislation proposed in the report, as members have not touched on it. Has he set in train the process of bringing in that legislation covering the new HSE board, the national health fund and what is proposed in the Sláintecare report, in other words, the accountability element?

Deputy Simon Harris: I will answer the speakers in reverse order beginning with Deputy Shortall's issues, many of which were similar to those raised by Deputy Collins relating to slippage and timefarmes. I want to be honest about this. I do not criticise anybody for being ambitious but some of the timeframes were somewhat unworkable, and I do not say that to be critical. We had a plan in May, it was debated in the Dáil in June - in fairness, Deputy Shortall noted the changes in Government - and the idea that we would have a lead executive, which the members and I would want us to have, in position in July was always going to be a bit of a stretch. We can probably accept that much. It is now November and I accept we do not have a lead executive. I take the point made by Deputy Shortall, as chair of that committee, of the need for urgency to be applied to this. I assure her that urgency is being applied to this. It is with the Public Appointments Service. There is an executive search currently under way nationally and internationally. The Deputy asked about head-hunting and if anybody can be directed through that process. Everyone needs to go through the process of the executive search. It is appropriate that there is one because we need to get the right person to do this job. That is where it is at. It will be done as quickly as possible. The process is under way through the executive search with the Public Appointments Service.

I take the point that colleagues made that they would have liked and expected that the lead executive would be putting in place the implementation plan. I also have to accept the reality that the Taoiseach, on his first day in the Dáil when he appointed his Cabinet, listed three things for me to do, one of which was to make sure we had a draft implementation plan ready for the end of the year, so I did not wish to stall on the issue. It is a draft implementation plan with the wording used in the Sláintecare documentation. There will be an opportunity for the lead executive to finesse that and to have an important input into its own team as well. We have brought in consultants to help formulate that in a quick timeframe, and that is a matter of public record. I hope to be in a position to share that once I go to Government with it very early in the new year. This committee is probably the appropriate body to consider that and I will be happy to debate and talk it through with colleagues.

On the ehealth programme, I take the point that we have to spend to save. We rolled out the ehealth records in the Rotunda Hospital the other day where we now have digital recordings with regard to babies, similar to the records of other babies but with an electronic health record. It is the third maternity hospital in which we have rolled out the programme. We have to do

much more of this and to do it much quicker. I hope that will be reflected in the ten-year capital plan. Clearly that does not mean that we will not be doing it for ten years. It should enable us to speed up on some of that.

I note the context in which Deputy Shortall said the impact study was to be done. I would point out that Sláintecare says that this would be disentangled over a five-year period and it refers to commencing that in the second year. The study will be completed within nine months, so by the end of next summer we will talking about the outcome, which will provide us with a good basis. For the record of this committee, my view on that is clear in that I support the disentanglement of public and private practice. I said it at the Irish Hospital Consultants Association conference in Limerick but the impact study is a prudent way to go as well. I am clear about what I would like to see happen in that regard.

On the issue of the consultant contract, there is a need for a new contract. The programme for Government commits to it. It will probably be possible to implement Sláintecare without a new consultant contract but, nevertheless it is something we need to address.

I thank Deputy Shortall for acknowledging last night's television programme it. It was fair but what we do not want to do is to group everybody together and with respect to the good elements that are happening to have those people discouraged or demotivated. It is fair to say that a significant minority have brought the system into disrepute and have let down many of their colleagues. At a hospital group level, people are meant to be ensuring these contracts are fulfilled. I cannot be satisfied that is happening now on the basis of what we saw last night. Senator Conway-Walsh asked did I know about it or was I surprised. I think everybody in this room has heard an anecdote or a concern about whether doctor X or doctor Y is doing too much private practice. Through its excellent surveillance work, RTÉ "Prime Time" programme has given concrete evidence on that.

As to what I am going to do about it, I spoke to the HSE again this morning on the issue. I have been informed, as I would expect to have been the case, that there will now be formal investigations into each of the cases highlighted in the programme last night. I do not want to say anything to interfere with that due process. Due process is important but the Deputy is correct in terms of what is meant to happen when somebody is in breach of their contract in terms of the fees being paid back when those fees are meant to go into a research and study fund. I expect those formal investigations to proceed and I have been made aware this morning that they will. I have also made it very clear, and the Deputy can believe me or not on this, but long before last night's programme we were discussing in the Department the need for having a more robust mechanism in place. I want an absolute assurance that in 2018 there will be robust mechanism in place, like there would be for any other health care professional, to make sure that people are fulfilling their contractual duties.

I would also make the point that there is a legal dispute ongoing with the consultants on the non-implementation of pay increases under the contract. It is likely that poor contract compliance will be argued strongly as part of the State's discussion. We cannot have a situation where some cohort is arguing in regard to the non-implementation of the contract where we now see significant concerns about the implementation of aspects of a contract that the contractor has an obligation to fulfil. I do not wish to say too much more than that other than I have been very clear here. I expect the HSE to provide robust mechanisms that will satisfy me and that, in turn, I can try to satisfy the Oireachtas that there is proper monitoring in regard to the contract. I thank the Deputy for acknowledging that it is not my contract, it is one we have inherited and about which I have significant concerns.

Deputy Billy Kelleher: Is there a potential conflict of interest between the HSE and the consultants in view of that fact that stretched budgets are now an integral part of-----

Deputy Simon Harris: I missed the start of the Deputy's question.

Deputy Billy Kelleher: It there a potential conflict of interest between the HSE overseeing the implementation of the contract and the fact that some of these consultants are doing a lot of private work through the public hospital system, which, in effect, funds the public hospitals through the stretched budgets that are demanded of them?

Deputy Simon Harris: Not all consultants are employed by the HSE. I should have made that point in the interests of clarity. Some of these consultants may be employed by voluntary hospitals. That is another impact of our system.

Deputy Róisín Shortall: What about the contract?

Deputy Simon Harris: Yes, but they are not all employed by the HSE. That is my point. I take the point the Deputy makes. I do not, nor will I, accept as an excuse from anyone working in the health service at any level that asking the HSE to adhere to two separate legal requirements is something beyond its capabilities.

The HSE is an implementer of law, not a maker of law. If the Oireachtas wants to change the law, it can change the law. The law at the moment in respect of collecting private income is such as it is and the legal situation with the contracts is such as it is. I do not believe it is unreasonable for me as Minister to expect, pending any changes these Houses may wish to introduce in line with Sláintecare or anything else, that the HSE can get on with it and satisfy both.

Senator Colm Burke: Under clause 20, subsection (g), of the contract the Department is entitled to carry out an audit. Does the Minister now envisage doing that if there is a question mark over, or a conflict of interest in, the HSE doing that audit?

Deputy Simon Harris: I wish to be clear: no one suggesting that the HSE should do the audit. What I am saying clearly as Minister is that I want my Department to be able to satisfy me in 2018 that people are adhering to the consultants' contract in full and that where they are not, appropriate steps have been taken.

Senator Burke is right. We have the ability to carry out an audit function. The process I have articulated is effectively the utilisation of that function. I am not ruling out a more comprehensive audit should the need arise. My priority must be, as it should be, to ensure that we have robust monitoring mechanisms in place.

Senator Colm Burke: The Department does have the power. Is that correct?

Deputy Simon Harris: The Department has the power to audit, absolutely. However, the responsibility is with the employer, the HSE. The HSE should not shirk in that regard either.

Deputy Billy Kelleher: The Minister said the responsibility is with the Department to carry out audits if the contracts are not being adhered to.

Deputy Simon Harris: That is correct. What does Deputy Kelleher think I am doing?

Deputy Billy Kelleher: I am not singling out the Minister. It is the system. No one is surprised by what we saw yesterday. However, we are surprised that we did not have the tangible

evidence. We have all been raising these issues for years.

Deputy Simon Harris: What I am saying is that we are using the powers that my Department has to hold the HSE to account on this matter. The HSE and the Department are engaging, and have been for some time, with a view to having a robust mechanism in place that can satisfy me. I can be told now what nurses turn up and what nurses do not turn up. I should have, but I do not necessarily have, those data available to me in respect of all the consultants. The programme last night highlighted the difficulties in that regard.

Deputy Róisín Shortall: As I said earlier, a cohort of clinical directors are being paid €46,000 to supervise their colleagues. What are they doing?

Deputy Simon Harris: There is a responsibility on the clinical directors. There is a responsibility on the hospital group chief executives as well. I must be careful because I have just said that there will be formal investigations into potential breaches of the consultants' contract – I am using my words carefully because we all saw the programme. I want to allow due process.

Deputy Róisín Shortall: The Minister said non-compliance with the contract would be argued strongly in court in respect of the case the consultants are taking. Surely, that argument has been used already with the initial findings of the court.

Deputy Simon Harris: Yes, but we have not been in court.

Deputy Róisín Shortall: How can people claim to get back money for work they did not do? Have we been using that evidence?

Deputy Simon Harris: I have to be careful not to go much further than what I have said already in order not to jeopardise the position of the State. The delivery of contracts works both ways. The employer has an obligation and the contractor has an obligation as well. Contractors have decided to take legal action against the State. I am making the point that the State will robustly defend these actions and will use all levers at its disposal, including the matter of compliance or non-compliance with the contract.

Senator Rose Conway-Walsh: I wish to bring the discussion back to my question. The Taoiseach, Deputy Varadkar, was the Minister for Health in 2014. I asked the Minister whether he authorised the non-compliance matter. He was Minister at the time. Did he authorise the non-collection of the non-compliance data? Did he stop the collection of the non-compliance data?

Deputy Simon Harris: I am sorry, I was not avoiding the Senator's question. I was merely dealing with the questions of Deputies Shortall and Joan Collins. I was not in position. The question was whether the Taoiseach knew. My understanding is that this happened when functions were delegated to the hospital groups and that the hospital group had responsibility. My Secretary General informs me that it would not have been a decision made by the Minister of the day.

Senator Rose Conway-Walsh: He was not informed of it at all. Is that correct? The matter needs to be questioned. I do not think it is funny. There is extraordinary wastage of money in consequence. People have had their treatment delayed. We outlined the figure earlier for those who had not been seen as a result. We are told the Minister for Health at the time would not have been informed of such a decision. I am bamboozled by how the Minister might fight this in a legal situation if he does not have the data dating back to 2014.

Deputy Simon Harris: This is the world in which we live. I did not say that the current Taoiseach, the former Minister for Health, had or had not been informed, because I am not that person. What I have said is that it would not have been a decision made by the Minister of the day. It was an operational decision made by the HSE. That is all the information I have to hand. I have confirmed that information with my Secretary General. In terms of what people knew and did not know at a given time, I can only answer in respect of myself, but that is my understanding of it.

The Senator asked about Saolta costs. We will find out. The group structures are delivering benefits. Let us consider the RCSI hospital group, for example. The hospitals, including those in Beaumont, Drogheda and Cavan, are working together and pooling their patients to work on waiting lists and drive down waiting times. Synergies are being created between the hospitals in Roscommon and Galway. I will arrange for the information in respect of the costs to be provided to the Senator by the HSE. I do not have it to hand.

Senator Rose Conway-Walsh: Can the Secretary General give an idea of why the collection of the data was stopped in 2014?

Mr. Jim Breslin: I joined the Department in the second half of 2014. The then Minister, Deputy Varadkar, was appointed that summer. My understanding – this is not based on direct personal information – is that the HSE took that decision within the HSE in the context of the introduction of hospital groups and hospital group chief executives. The idea was that that responsibility, rather than staying at national level, would be delegated to the group chief executives. It was an operational decision made in the HSE. There was no legislative or policy decision made in the Department on that. I do not have any more information on who knew what at the time.

Deputy Simon Harris: I imagine Senator Conway-Walsh will accept that the likely direction of travel with, and in advance of, Sláintecare is that we will see more functions devolved from national to regional level. I believe that is appropriate. We have hospital group chief executives and board chairpersons. As Deputy Shortall has pointed out, we have hospital and hospital group clinical directors. The HSE informed me today that it will meet my expectation of a formal investigation into each of these. I think we need to let that take place. It is important that these issues are formally investigated.

Senator Rose Conway-Walsh: The responsibilities are being delegated to regional level. However, we have seen with something as serious as this that they are not being carried out. I think that raises questions.

Deputy Simon Harris: Obviously, having looked at the programme last night, it is clear that there have been cases in which this was not carried out correctly. That is obvious to anyone who watched the programme. I want to formally investigate it. It is a jump to suggest that no hospital group chief executive, hospital manager or clinical director is managing this. We need to identify where it is not happening and why not and we need to ensure it does not happen again. The point about data is important. It is part of the reason I want to talk about robust monitoring being provided. We need to have exact data on what is actually happening. I do not believe we have had adequate data to date.

Senator Rose Conway-Walsh: Someone somewhere made that decision and that person needs to be held to account.

Deputy Róisín Shortall: The Minister referred to formal investigations. I welcome that in respect of the people who were highlighted in last night's programme. Clearly, this is a systemic problem that must be dealt with. We need to change the systems in place that allow abuse of the public purse at present. I am repeating my request. The National Treatment Purchase Fund, NTPF, audit was carried out and published two weeks ago. Can the Minister ask the NTPF to provide the data in respect of the status, public or private, of the patients concerned? That would be interesting.

Another question I asked relates to Sláintecare and was dealt with in the Sláintecare report. It relates to the setting of targets for public hospitals to increase the number of private patients they are taking. Can the Minister end that practice as a matter of urgency, stop the stretch targets and let us see how we can get from 20% down to 0% over the next five years as recommended in the report?

Deputy Simon Harris: I will consider that in the context of the implementation plan, implementing Sláintecare and all of the steps we need to take.

In regard to the National Treatment Purchase Fund, NTPF, it has those data and I have no difficulty with it sharing them with the Deputy or the committee. I do not honestly know but I will have the question asked.

In regard to the reference to the problem being systemic, I assure the Deputy that I would not be taking the steps I had already commenced and will now intensify further if I believed it was simply a case of one or two or half a dozen doctors not fulfilling their contract. I believe there is a missing piece here in terms of being able to accurately monitor compliance with a contract in which the taxpayers invested a significant amount and depend on to deliver for patients. That is why I want a more robust monitoring mechanism.

Deputy Joan Collins: The Minister did not reply on the €600 million that was supposed to be for 2018. Has he got that funding earmarked? When will he bring forward the legislation or has he put that in process?

When does the Minister see the position of chief executive officer, CEO, of the implementation office being filled? Will he come back before the committee in January because we will not get a chance to ask the questions again in a way that I hope we can get a direct answer?

Deputy Simon Harris: On the €600 million, I think I heard Deputy Collins speak about that on a radio programme. She knows the budget figures and I know them. The Government allocated an extra-----

Deputy Joan Collins: This is for Sláintecare.

Deputy Simon Harris: The Government allocated approximately €600 million in regard to Sláintecare. A number of those measures were what I described as Sláintecare-friendly or Sláintecare enablers. Did we allocate €600 million specifically for Sláintecare? No, we did not. Obviously, we had to operate within the resources available.

Regarding the legislation, most of it is being considered in the context of the implementation plan. That is the current status of it, with the exception that I am at an advanced stage with the Health Service Executive, HSE, board legislation, which is quite straightforward legislation. I expect and hope to be able to bring that to Cabinet around the same time as the implementation plan, with the agreement of Members of the House. It is a matter for the House but if we

could take that swiftly, I would like to see a priority attached to it in terms of getting it passed as quickly as possible in 2018 in order that we can have the board in place in 2018. I will return to the other legislation in the context of the implementation plan.

Chairman: On that point, does the Minister guarantee that he will provide an implementation plan before the end of this Dáil session?

Deputy Simon Harris: I am due to receive an implementation plan by the end of the year. I have to bring it to Cabinet first so I cannot be prescriptive in terms of when the last Cabinet meeting will be but what I can say is that I will have the implementation plan by the end of the year. I will bring it to the next available Cabinet meeting as soon as I have it and I will then share it with this committee immediately.

Chairman: So it will be 2018.

Deputy Simon Harris: I cannot say that.

Deputy Joan Collins: I am concerned that the Department is bringing in the draft plan without the lead person in place who will have to come in and-----

Deputy Simon Harris: The Deputy makes a fair point that somebody would come in, inherit a plan and be told to go off and do it. That is not the idea. We will have a draft implementation plan. Ultimately, the lead executive will have the job of finalising the plan. The plan can be scrutinised here and it will go to Cabinet but I have been charged by the Government, and by the Taoiseach specifically, to bring forward a draft implementation plan by the end of the year. That is what I am duty bound to do. I will share it with the committee. The dates of when it can go to Cabinet are above my pay grade. I cannot be overly prescriptive but the commitment I and the Taoiseach have given is that it will be by the end of the year and that will be honoured.

Chairman: There is an expectation that the implementation office would devise an implementation plan independent of the Department and the Health Service Executive but now the implementation office will be given a plan devised by the Minister.

Deputy Simon Harris: No. I do not believe that is fully fair. The Sláintecare report also states that it wants the implementation office to report and be accountable to me. The idea that the Minister for Health has no role in health reform and that my Department would not have an interest in health reform would be a stretch. I agree that there need to be outside external voices. I cannot make the lead executive arrive any quicker. I do not wish to stall the progress on the draft implementation plan. I do not think patients can wait for it and I am proceeding on that basis. I am the Minister for Health. I hold the seal of office. I take my job very seriously. I am responsible for health reform. I would welcome a lead executive. It has a future role to play. We have seen excellent examples with people coming in and reforming cancer services and the likes in this country with huge clinical expertise, communicable abilities and abilities to bring stakeholders with them but I cannot sit idle while we are waiting for this and that is what I am trying to do. We have brought in consultants to help bring an external perspective. We have seven people in the Department of Health working on this issue so I am doing the very best I can to prepare a draft implementation plan, with the emphasis on the word "draft". Obviously, it will be the lead executive's plan and he or she will be responsible for delivering the plan.

Deputy Joan Collins: Would it be going outside the realm to ask the Minister to provide us with the names of the people on that-----

Deputy Simon Harris: I have to refer to my Secretary General.

Deputy Joan Collins: -----including consultants and so on who are devising-----

Deputy Simon Harris: It is in the public domain but my apologies. McKinsey are the consultants and the civil servants are Ms Laura Casey, who is to my left, and six others. We can provide the Deputy with any detail that is appropriate.

Deputy Joan Collins: I appreciate that.

Mr. Jim Breslin: It is fair to say that beyond the six there are staff involved across the Department. It is the biggest work item within the Department and we are pulling people from across the Department, and other experts as required. It is quite a big operation.

Chairman: On behalf of the committee I thank the Minister for coming in today, as well as Mr. Jim Breslin and Ms Laura Casey for giving evidence relating to progress on the Sláintecare reform programme. As there is no other business, this meeting of the joint committee is adjourned until 9 a.m. on Wednesday, 29 November. Is that agreed? Agreed.

The joint committee adjourned at 12.16 p.m. until 9 a.m. on Wednesday, 29 November 2017.