DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 11 Iúil 2018

Wednesday, 11 July 2018

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
Stephen Donnelly,	Colm Burke.
Bernard J. Durkan,	
Alan Kelly,	
Margaret Murphy O'Mahony,	
Kate O'Connell,	
Louise O'Reilly.	

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

Business of Joint Committee

Chairman: As we have a quorum we will start the meeting. I propose to deal with housekeeping matters in private session. Is that agreed? Agreed.

The joint committee went into private session at 9.09 a.m. and resumed in public session at 9.33 a.m.

Scrutiny of EU Legislative Proposals

Chairman: In regard to proposed EU legislation, is it agreed that COM (2018) 244, a proposal for a Council recommendation on strengthened co-operation against vaccine preventable diseases, does not give rise to subsidiarity concerns but warrants further scrutiny? Agreed. In that regard, is it agreed that we will send a letter to the Department requesting it to outline its concerns regarding the role of the European Commission in the formation of immunisation policy and that we would also send a letter to the Commission? Agreed. Is it agreed that COM (2018) 253, a proposal for a Council implementing decision on subjecting two new psychoactive substances, cyclopropylfentanyl and methoxyacetylfentanyl, to control measures, does not warrant further scrutiny? Agreed.

I propose we suspend for a few minutes to allow our guests to take their seats.

Sitting suspended at 9.35 a.m. and resumed at 9.37 a.m.

Hospital Services: Discussion (Resumed)

Chairman: This morning we are meeting representatives from the Irish Hospital Consultants Association, IHCA, Irish Nurses and Midwives Organisation, INMO, and Irish Medical Organisation, IMO, to discuss the ongoing hospital overcrowding issues and the delays in admissions and outpatient appointments. On behalf of the committee, I welcome Dr. Donal O'Hanlon, Dr. Laura Durcan and Mr. Martin Varley of the IHCA; Ms Phil Ní Sheaghdha and Ms Martina Harkin-Kelly of the INMO; and Dr. Peadar Gilligan and Ms Susan Clyne of the IMO.

I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the joint committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter only to 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. They are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. I advise the witnesses that any opening statements they have made to the committee may be published on

the committee's website after this 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 by name or in such a way as to make him or her identifiable.

I call Mr. Martin Varley to make his opening statement

Dr. Donal O'Hanlon: Will I go ahead and do so?

Chairman: Yes, of course.

Dr. Donal O'Hanlon: The association welcomes the opportunity to address the joint committee on ongoing overcrowding issues in hospitals as well as the delays in admissions and outpatient appointments. The fundamental causes of the overcrowding and delays in providing care to patients are the capacity deficits in terms of acute infrastructure, hospitals consultant numbers and other resources. Demographic factors, including our increasing and ageing population, have led to significant increases in demand for health care, including acute hospital and mental health services. However, decades of underinvestment, combined with one of the lowest number of consultants on a population basis in the OECD, have led to significant and growing capacity deficits. The national development plan, NDP, commitment to provide €10.9 billion in capital funding for health services in the next decade is an important first step in addressing the overwhelming acute hospital capacity deficits that the association has highlighted. The capacity deficits are one of the main causes of delays in providing acute hospital care to patients. This has been acknowledged in the capacity review published earlier this year. The NDP commitment to fund the expansion of our acute public hospital capacity is long overdue, as our acute hospital and mental health services are at breaking point, with unacceptable delays being endured by patients in obtaining emergency and scheduled care. The current shortage of acute, ICU and rehabilitation hospital beds, mental health beds, essential equipment and hospital consultants is preventing the provision of essential hospital care that the population needs and deserves. The NDP's proposal to put in place an additional 2,600 acute hospital beds must be assessed by reference to the current hospital and emergency department crisis. It is important to take account of the fact that acute hospital inpatient beds were cut by 1,400 in the past decade, at a time they should have been increased, at least in tandem with the country's increasing and ageing population.

The deficit in acute public hospital beds will not be remedied in full by the proposed expansion of 2,600. The ESRI projects a 37% increase in patient demand for hospital services by 2030. This confirms that a greater increase in hospital bed capacity than currently proposed will be required in future. It is now vitally important, however, that an annual commissioning plan is agreed to put the additional 2,600 acute beds in place much earlier than the ten-year period proposed in the NDP. This is of paramount importance in order that our hospitals can deliver safe, high-quality hospital care to patients without the unacceptable current reliance on trolleys and increasing waiting lists.

The association has highlighted that the cost of implementing the proposals in the Sláintecare report has been understated, and will cost the taxpayer €20 billion if implemented over ten years, compared with €2.8 billion stated in the report. In its submission to the independent review group in February, the association also outlined that the removal of private health insurance income from public hospitals will have a devastating effect on hospital operating budgets, crippling their ability to treat an ever-increasing number of patients, unless central funding fully

provides the resources to address the growing capacity and operating deficits, while also replacing the insurance income foregone.

It is astonishing that the Sláintecare report contains an underestimation of this magnitude. The proposal to remove private care income from public hospitals by itself will cost the public hospitals €6.5 billion over a ten-year period. When adjusted for inflation, the estimated cost will be in the region of €8 billion per decade, which is €800 million in lost hospital income per year. Based on our collective experience, the IHCA and its hospital consultant members have no confidence that the loss in private health insurance income will be replaced by the Exchequer. This is especially a concern as the State has for decades struggled to adequately fund the public acute hospital system. In the context of the ESRI projected increase in demand for hospital care by 2030, removing the private revenue stream defies logic and will further cripple the public health service.

Considering the resultant under-resourcing of public hospitals, it would only serve to exacerbate the existing consultant recruitment and retention crisis. This proposal will cause an exodus of experienced consultants from the public hospitals, thereby reducing the availability of highly specialised clinical services to patients in public hospitals. The difficulties and challenges faced by the public hospital system are a consequence of years of under-funding and under-resourcing, which have severely restricted and reduced the capacity of public hospitals to meet increasing demand.

The association's survey of 317 recently appointed consultant members, which was conducted in the past week, confirms that acute hospital and mental health services face an escalating and unprecedented consultant recruitment and retention crisis because of the ongoing blatant discrimination by the State and health service employers against new hospital consultants. Almost all respondents to the survey agree that the lower salary terms imposed on new consultants are having an adverse impact on the delivery of patient care due to the large number of consultant posts that cannot be filled, are filled on a temporary basis or left unfilled. More than 70% of new consultants have confirmed that they will seriously consider resigning from their public hospital posts unless the discriminatory salary terms are corrected. Furthermore, the vast majority of respondents - 95% - strongly agreed that the lower salary terms do not reflect the importance of the work, and level of responsibility that they hold.

This survey has provided categorical evidence that our highly-trained specialist consultants will not continue to work in our health services if the persistent and blatant discrimination against them continues. Recently appointed consultants are on salaries significantly below those of their pre-October 2012 colleagues, some of whom are currently being paid up to 57% more. It is not surprising that 72% of new consultants ranked equal pay for equal work as the most important aspect of their working terms and conditions.

In addition, 92% of the respondents confirmed that they were aware of colleagues working abroad who will not return to work in the Irish public health system as a direct result of the lower salary terms. The results of the survey should set alarm bells ringing at Government level, as it is now abundantly clear that consultant delivery of services to patients is on a cliff edge, because it is being fundamentally and critically undermined by the State's persistent discrimination against these internationally sought-after specialist hospital consultants.

The pursuit of this discrimination has resulted in approximately 450 approved consultant posts, a full 15% of the total, which cannot be filled on a permanent basis. About half of these posts are vacant and some are filled on an agency basis, at costs which are up to three times the

discriminatory salaries being paid to the recently appointed consultants. The age profile of the consultant workforce suggests this problem will increase dramatically, as 25% are over 55 years of age. The current two-tier pay system for consultants is the major obstacle to recruitment of new consultants. The new entrant salary is not competitive in the global market for consultants, and is discriminatory in the extreme towards new hospital consultants.

I thank the committee for the opportunity to discuss these capacity issues in infrastructure and consultant staffing and I look forward to answering any questions members may have.

Chairman: I thank Dr. O'Hanlon. I call Ms Ní Sheaghdha to make her opening statement.

Ms Phil Ní Sheaghdha: Go raibh maith agat, a Chathaoirligh.

I thank the committee for the opportunity to present our issues in respect of the trolley crisis. As we said in our letter in June when we requested this meeting, we have concerns regarding the count, which we have been conducting for decades, and the point that it reached in June of this year. That is why we sought this meeting. It is clear from our statistics, which are accepted as a measure of overcrowding in the public health service, that we will exceed the high number that we reached last year for those admitted for acute hospital care and for whom there were no beds. It was just under 100,000 patients last year. In the time available, I will concentrate on three main issues we believe the Oireachtas can influence. We have provided a comprehensive background note on where we think the issue has come from. The reasons are not going to be any different to those suggested by my colleagues from the IMO and the IHCA. I am not, therefore, going to read them but will be happy to take questions. At paragraph 1.7 of our submission, we advise that the Sláintecare report, the Tallaght investigation by HIQA in 2012, the ESRI report of October 2017, the capacity report of 2018 and the Nevin Economic Research Institute's working paper on equality in Irish health care produced in May 2018 all inform our submission. They are all referenced. The overwhelming issue for us is capacity and staffing, followed by the issue of pay. Fundamentally, we believe the public hospitals system is in crisis and that bed capacity is not sufficient to meet demand. We confirm the daily effect of this on patients and the nursing staff and medical staff generally who work in these departments. It leads to early decisions to leave places of work and it has, unfortunately, subjected our members, in particular, to a high incidence of violence and aggression in the workplace which is completely unacceptable.

I will read the submission starting from page 4. Targeted protected additional funding is required that is linked with significant reform that supports the provision of services at the front line rather than the bureaucratic processes that exist within health. The problems that need to be addressed include the reconfiguration of divisions within the HSE so that all services are managed in an integrated service delivery model. The current mode of divisional budgeting and management of services works against efficiencies and cost savings across the service. There is a need to significantly increase bed capacity in the acute and step-down care areas, expand the number of community intervention teams and expand nursing services in long-stay facilities to relieve pressure on acute hospitals. The annual stand off between the HSE and Department of Health has commenced this year. We have all heard the projections of budget overruns. What that means for those who depend on public health services is that their services have been cut. In many instances, home care packages are no longer available in certain areas while services which are funding-dependent and demand-driven are no longer available to citizens, which is simply unacceptable. Patients have no alternative then but to attend emergency departments for services. Independent oversight of appropriate allocation is not available and must be introduced. This will require a managed accountability for subsequent spending. The model

adopted for capital allocation protections should be mirrored to protect funding for specific services. Funding for front-line services must include funding for staffing plans and service developments. The INMO has publicly supported the Sláintecare report and now calls on the committee to recommend that Government must prioritise the required funding to execute and implement the transitional plan and ongoing annual budget increases. These must be protected and considered central to all Government policy to deliver the much-required reform.

The INMO has engaged with the HSE on staffing over the past two years. We have had disputes on staffing and an inability to staff new beds that have come on stream in care of the elderly and acute services. There is an acute shortage of nurses and midwives. I concentrate on nurses for this part of the submission because the maternity strategy is a different matter and does not affect emergency department posts. We identified nursing grade vacancies in 2016 which were very close to 350 in emergency departments alone. We reached an agreement with the HSE that to provide the best care to patients who were boarded in emergency departments and for whom ward capacity was not available 183 new nursing posts were required. Neither of those targets has been met and the posts remain unfilled. With the assistance of the WRC following a dispute, we agreed a funded workforce plan for 2017. The target for 2017 was to expand the nursing and midwifery workforce by 1,224 and that target was not reached. The number reached by December was just under 800 of the 1,224. That is not because recruitment is not taking place, it is because retention has become a bigger problem than recruitment. Currently, the average time to recruit a nurse is six months. We do not have agreement on a funded workforce plan for 2018 and we are in dispute with the HSE on the delay. We were supposed to have an agreement in November 2017 and as late as yesterday the HSE advised us that it will not have its final draft until later this week or possibly next week. It is now July. That means no matter how many nursing posts the HSE funds this year, they will not be standing beside patient beds before 2019. That reduces completely the ability to increase capacity.

The combination of generally low pay for nurses and poor working conditions within understaffed services, including emergency departments, is a significant issue in the recruitment and retention of nurses in the Irish health service. It is clear to the INMO that the issue of nurses' pay needs to be urgently addressed to assist in solving the problem of staffing within emergency departments. A review of nurses pay is allowed within the provisions of the public service stability agreement. A report from the Public Service Pay Commission is imminent. The commission was tasked with examining the influence of pay on recruitment and retention issues which it identified as existing within the professions of nursing and midwifery and the medical profession in its first report. The commission is due to report at the end of July following its consideration of submissions and its own research. If low pay for nurses is not corrected, we will be unable to recruit and retain the nurses required to care for our citizens inside and outside the hospital system. That is a simple matter of fact. We will also be unable maintain present bed capacity, never mind the increased capacity we all agree is required to grow services for our ageing population. We have reached a pivotal tipping point in recruitment and retention of nursing staff and it will have detrimental effects if not addressed by Government. These effects will include the closure of beds and lengthening waiting lists. The framework on nurse staffing was published by the Department of Health and accepted by it as the determinant of nursing posts required to look after patients based on a scientific determinant, taking patient dependency and outcomes and skills mix into account. It must be fully funded and implemented to determine how many nurses are needed. Unfortunately, the initial draft of the funded workforce plan for 2018 contains no allocation of funding to implement the framework despite the commitment in the 2018 HSE service plan.

What are the effects of all of this on the front line and what happens to patients when they attend our emergency departments having absolutely no alternative? What happens to our nursing, medical and other staff who are trying to provide the best care they can? Our members have advised that the constant pressure of overcrowding, inadequate staffing levels, delayed care to patients and negative patient outcomes are leading them to personally suffer burn out and stress at an early stage in their careers. Nurses are also reporting to the INMO that they find themselves answering and apologising to the public before internal and external enquiries which they regularly must attend to explain inadequate services. They clearly outline their belief that the HSE does not support them appropriately when matters outside of their control cause patients to have poorer outcomes and where inadequate care is provided in unsuitable environments. Nursing staff feel a duty to raise concerns about patient care, as do their medical colleagues, as it is a fundamental professional responsibility of a registered nurse. It is unacceptable for professional nursing staff to feel that they are unsupported by their employers in dealing with the consequences of systematic failure in the health service.

A recent HSE report on assaults against staff in acute statutory hospitals indicates that 9,901 reported assaults were recorded between 2008 and 2018. To be clear, that report does not cover any of our voluntary hospitals, which represent a large portion of the employment census for nurses and midwives. More than 70% of those reported assaults were against nursing staff. There is clear evidence that the numbers of verbal and physical assaults increase when long waiting times and inadequate and inappropriate staffing are features of healthcare provision. Unfortunately, we are finding that many of the assaults are career-ending for the people we represent. We believe this is a manifestation of poor planning and a lack of commitment to fund and implement agreed reform and national agreements. It cannot be ignored and simply frowned upon without the Oireachtas making an unambiguous commitment to front-line nursing staff that it will provide adequate and protected funding and for reform to correct the unacceptable experiences of one third of the entire workforce of the health service.

The reality of the emergency department nurses' daily and nightly experience is described as deep frustration and anger at the fact that they feel unable to care for their patients' fundamental needs in a way that they would wish to and that they are trained to do. The physical environment in which patients are crammed together within touching distance of each other and with little or no privacy and poor hygiene facilities is completely inadequate to maintain a patient's dignity and privacy. It is dehumanising and degrading and an experience we should not allow to continue for citizens. We already know from our figures from June this year that this problem is going to get worse before the end of the year and that it is going to be much worse than it was last year.

We believe the time for reviewing and analysing the emergency department overcrowding problem is over. Our members require immediate action as they cannot continue to tolerate this situation for themselves or their patients. We are heading into winter which is very likely to be worse than in 2017, unless appropriate action is taken, including proper planning and the provision of focused funding. Those in HSE management often rush to defend the work they are doing to solve the problem. The reality is it is getting worse and we need decisive action at the Cabinet table to implement and fund the measures that will actually work. The alternative is simply not tenable for citizens and certainly not for our members.

We again repeat our request which we set out at the start of the submission that a commitment be made to ensure protected, targeted and sustained investment to allow real reform; to ensure the bed capacity report will be implemented; primary and long-term care services will be

developed, as set out in the Sláintecare report; and bed capacity in the acute hospital sector will be expanded. Workforce planning for nursing based on patient needs must be funded to ensure adequate front-line nursing staff. The recruitment and retention of nurses are dependent on the correction of the low pay rates for those in the nursing and midwifery grades who are the lowest paid professionals in the public health service. Globally, they fare very badly with those in the countries' that are also short of nurses but which are recruiting our graduates and, increasingly, our practised and experienced nursing workforce.

I thank members for their time. I will be happy to take questions on the issue.

Chairman: I thank Ms Ní Sheaghdha and call Ms Clyne to make her opening statement on behalf of the Irish Medical Organisation.

Ms Susan Clyne: The Irish Medical Organisation, IMO, thanks the Chairman and committee members for the invitation to discuss the ongoing overcrowding issue in hospitals, as well as delays in admissions and outpatient appointments. For more than a decade the IMO has been highlighting the capacity issues across the health system.

Ireland has a growing and ageing population. For many decades the proportion of the population over the age of 65 years remained static, but it has now begun to change and the pace of that change will accelerate rapidly in the years ahead. In simple terms, an additional 20,000 people each year will reach the age of 65 years and, as life expectancy increases, the number aged over 80 will double. In the last ten years the total population has grown by 300,000, or 7%, while the population aged over 65 years has increased by 166,000, or 34%. That gives an idea of the scale of the problem. At the same time, the healthcare system has undergone significant budget cuts. Between 2007 and 2014, both staffing levels and the number of inpatient beds fell by 13%. Public health expenditure only began to increase from 2015 and even at that, it failed to keep pace with demand. The pressure exerted by demographic changes and financial cuts is manifesting in unprecedented overcrowding in emergency departments and waiting lists for outpatient appointments and elective procedures.

Bed occupancy rates in hospitals have risen to an average of 97%. In model 4 hospitals that figure increases to 104%. These rates are well above internationally recognised safe occupancy rates of 85% for inpatient care and 80% for critical care. The HSE's full capacity protocol which is designed to act as a safety valve when emergency department functioning is compromised has become the norm. The protocol was implemented on hundreds of occasions in 2017. International evidence shows that high bed occupancy rates are associated with a number of adverse factors, including increased risk of healthcare associated infections such as MRSA, increased mortality, an increased probability of an adverse event and risks to staff welfare.

A significant contributor to long waiting lists is inadequate medical staffing levels. Public health services are facing an unprecedented crisis in recruitment and retention in the medical and other health professions, as clearly evidenced by the fact that we have at any given time more than 450 vacant consultant posts. That is in the context of a total consultant workforce of approximately 3,000; therefore, it is significant. Almost 90% of consultants who trained in Ireland but who are currently working abroad have indicated they will not return owing to the discrimination on pay scales. One third of existing consultants are considering taking up a post abroad in the foreseeable future. In 2017 the Public Appointments Service, PAS, produced figures which confirmed that the public health service was unable to attract applicants. For one in ten consultant posts no applications were received and the PAS could not identify a suitable applicant for 22 of the 84 posts. That is a real change in what would have been a highly competi-

tive market ten years ago in which consultants, nurses and other healthcare professionals were vying for jobs in Ireland. Almost 700 GPs are due to retire in the next few years, while, at the same time, 30% of GP trainees are intending to emigrate. Almost 20% of recent GP graduates have emigrated and a further 70% believe they may do so in the near future. That means that a growing number of GMS lists are attracting few or no applicants. Again, they were highly sought after lists, for which there was a lot of competition, but now we see nobody even applying for the posts.

Non-consultant hospital doctors, NCHDs, or doctors in training, are leaving the system in large numbers across all specialties and, alarmingly, it is happening after the intern year, the first year of training. That cannot be explained by the notion that doctors normally go abroad for training. They are doing so very early. There is huge apathy and they believe they will get through the first year and then go abroad to a system that values them and they have no intention of returning. Two thirds of NCHDs perceive pay to be the primary reason for emigration, while 83% believe the pay disparity at consultant level will impact on their decision on whether they should apply for consultant posts in Ireland. Irish trained doctors at NCHD level are three times more likely to emigrate than their UK counterparts. We hear a lot about the struggles of the NHS, yet in Ireland NCHDs are three times more likely to emigrate. We cannot hope to reform or reconfigure health services unless and until they are capable of attracting and retaining sufficient numbers of doctors, nurses and other healthcare professionals to deliver care to patients. That is not the case.

This is a patient care issue. We should not continue to spend money on short-term measures without significant and sustained investment at the same time in the public health service. The annual budgetary allocations do not even keep pace with current service levels and demand. We are not investing in health services. We have had numerous reports, including Sláintecare, the health service capacity review and A Future Together - Building a Better GP and Primary Care Service, all of which show that we need to invest in increasing capacity across the health system, in tandem with a significant budgetary allocation to allow for service development. The main point the IMO makes is that sometimes we tend to focus on one issue in the health service and think that if we provide funding, it will solve everything. The reports all show that it needs to be funded across the board and that everything must happen at the same time because otherwise we are playing a zero sum game and the problems are only going to manifest somewhere else in the service.

There are five key areas the IMO asks the committee to consider for urgent action. The first is increasing capacity in the acute hospital system. The health service capacity review shows that we immediately require approximately 1, 200 additional inpatient beds and 50 adult critical care beds in order to meet safe bed occupancy levels. It is not to meet demand but just to treat patients in hospital safely. Given that the majority of inpatient admissions now come through the emergency department and there is a considerable backlog for outpatient appointments and elective procedures, the number required is likely to be even higher. We have 1,531 fewer inpatient beds in the hospital system compared to 2007 and this is at a time when the population is growing and, as a result of demographic changes, the elderly population, in particular, is increasing. An immediate assessment of the number of acute beds available is required with the financial and manpower resources made available to upgrade and reinstate beds along with a detailed plan for investment in bed numbers into the future.

As is the case for our colleagues in the INMO, it takes a long time to recruit doctors, as it does nurses. Six months would be a fast turnaround to recruit a doctor into the system. Unless

we start identifying, planning and resourcing now, we have no hope in 2019 of making any significant changes. We need to increase the number of consultants across the hospital system. We currently have just 1.43 specialists per 1,000 population compared to a western European average of 2.4 per 1,000.

The Report of the National Task Force on Medical Staffing 2003, often referred to as the Hanly report, set out ratios of consultant to population that would need to be met to provide a consultant-delivered service, which we will all agree is the type of service we should have. That would improve quality of care and patient safety, as important clinical decisions would be made faster and at a higher level. However, non-consultant hospital doctors, NCHDs, continue to outnumber consultants at a ratio of 2:1. We are short approximately 1,400 consultant posts based on current population figures. Given our current difficulties in recruiting and retaining consultants, urgent action is required, or we will continue to struggle to appoint the number and calibre of consultants we need to provide safe patient care. In view of the growing disparity in consultant pay, this has now become a more urgent problem. There were 450 vacant posts at consultant level when the disparity was at a lower level. Now the disparity has increased to, on average, €50,000 per post and it is almost impossible to see how we will get consultants to come into the system. Equal work for equal pay is a basic principle.

Another issue we would ask the committee to consider is to adequately resource the national clinical programmes. Those programmes and models of care such as the emergency medicine programme, the acute medicine programme and the model of care for elective surgery should be fully implemented and resourced. These programmes represent the most effective and efficient use of resources. As a service and as a State, we spent a long time writing reports, which we all agree is the right thing to do, but we then find there is no funding available, they are left on the shelf, nothing happens and the problem worsens. The acute medicine programme was originally set up to provide an alternative pathway to the acute system to allow general practitioners, GPs, to directly refer patients to acute medical units, AMUs. However, due to lack of capacity and under-resourcing of both the emergency medicine programme and the acute medicine programme, AMUs are no longer satisfying the original criteria and with the current overcrowding in emergency departments, they now simply serve as an extension of those departments around the country.

Waiting lists for inpatient procedures primarily affect patients awaiting elective procedures. The model of care for elective surgery, if fully implemented and resourced, will improve access, quality and cost by reducing waiting times, abolishing cancellations, optimising day surgery and average length of stay, standardising care, and optimising the use of theatre resources. It makes no sense for the National Treatment Purchase Fund, NTPF, to purchase care from the private sector while simultaneously having a policy decision that imposes budgetary constraints and rolling theatre closures and cancellations in the public sector.

We need to address delayed discharges with increased resources for long-term and rehabilitative care for patients. No patient should be in hospital longer than is necessary and everyone should be discharged to an appropriate setting. Failure to transition patients to the most appropriate setting increases costs and reduces efficiency as patients are in the wrong place for the type of care they need. While community intervention teams have helped to support early discharges for some patients, we need to invest significantly in long-term and short-term beds for elderly patients as well as in intensive home care packages. That needs to be seen as a priority, given the known demographic changes, not what might happen or whether we will have a bad winter.

We need to invest in general practice and chronic disease management. With an ageing population and growing rates of chronic disease, all the evidence points to the need to shift the model of care towards general practice and a GP-led primary care system. An extensive body of international research shows that continuity of care and a patient-centred approach that is specific to general practice is associated with reduced mortality rates, particularly in the elderly, greater patient satisfaction, improved health promotion, increased adherence to medication, and reduced hospital use.

Chronic diseases, including cancer, cardiovascular disease, chronic obstructive pulmonary disease, COPD, and diabetes account for approximately 40% of hospital admissions and 75% of hospital bed days. Acute services currently undertake an enormous volume of chronic care, at significant expense to the taxpayer, that could, if properly resourced, be managed in general practice. General practice will not immediately resolve hospital overcrowding, but, in the long-term, if we invest now in GP-led chronic disease management programmes, for which GPs are trained, along with capacity measures to build up medical and nursing levels in general practice, we can reduce future growth in demand on the hospital system and patients can be seen and cared for in the most appropriate setting. However, following years of austerity and extensive cuts to the resources available to general practice, the current system is under-funded and working to capacity. Financial emergency measures in the public interest, FEMPI, cuts reduced resources per general medical services, GMS, patient by 38%. The immediate reversal of the FEMPI cuts is required to restore stability to general practice before any new workload can be taken on.

We appeal to all members of the committee to urge the Government, in the context of the forthcoming budget, to seriously address the problems in our health system and recognise the damage caused by delays for patients in accessing much needed healthcare. We also ask the committee to recognise the potential for Ireland and those who work in the health services to deliver a first-class health system if sufficient resources were allocated to allow this to happen.

Chairman: I thank Ms Clyne. I will open the meeting to our members. The first three members to indicate were Deputies Margaret Murphy O'Mahony, Bernard Durkan and Senator Colm Burke. I call Deputy Margaret Murphy O'Mahony.

Deputy Margaret Murphy O'Mahony: The witnesses are all welcome and I thank them for coming before the committee. They all spoke about the recruitment and retention of medical staff. Bright people are entering the medical field in all specialties and many of them are emigrating. Ms Ní Sheaghdha said that many of our more experienced medics are travelling abroad, which is probably a new phenomenon. The newly qualified people tended to go abroad but it is quite worrying that we losing experienced people. They are being treated better abroad and they also receive continuous training there. The recruitment of people is straightforward but will the witnesses comment on what they believe can be done to retain people?

I would also like their opinion on the funding of local general hospitals. We have a good hospital in west Cork, Bantry General Hospital. If it was allocated more funding, it could assist the larger hospitals in Cork city. We are currently trying to enhance its rehabilitation and endoscopy units. If it was given a small allocation, it would certainly ease the pressure on the bigger hospitals and it would also assist the local people in that they would not have to travel quite a long journey to Cork city. I would welcome the witnesses comments on that point.

Are there any plans to broaden the Voluntary Health Insurance, VHI, incentive to home-fund step-down services, or are there any other community initiatives that would free up beds?

Do the witnesses believe that the Minister for Health is acting in good faith in the formulation of a new GP contract, which he promised to deliver before the end of this year? As we are now more than half way through 2018, do they believe he is acting in good faith?

Do the witnesses believe that incidence of people not showing up for appointments is slowing the system down? How can that be addressed?

Who makes the decisions in emergency departments at night on whether patients need to be kept in or sent home? Should this system be different or could it be different? Do the witnesses believe their members' hands are often tied due to worries about legal issues or implications?

Deputy Bernard J. Durkan: I welcome our guests and thank them for their frankness. We might agree with some of it but we have to ask questions as well. Pay parity is not something we can renegotiate in public. It is a matter between the relevant bodies, the HSE and the Minister. It would be inappropriate to suggest what should be done. With whom are we competing for places in the international sphere to attract people? Are we competing with the UK, France, Germany or the Netherlands, or are we competing with the Middle East? The idea that we can compete with the Middle East is a myth. It is not possible and we need to be careful about going down that road.

We need also to address the capacity deficiencies. This committee has discussed them many times over the past year or two. There is an urgent necessity to address them and that is being done in the context of Sláintecare. I am not so certain it will be possible to accelerate the programme. Dr. O'Hanlon referred to the under-costing by the committee on Sláintecare. I do not want to be a dampener on this subject but we have to bear in mind that the country still has a €210 billion debt following the recovery. The theory is that we recovered from the financial and economic crash; we have. We have almost got to current budgetary levels such that we can pay our way on an annual basis but we would not want to fall asleep on it. Rather than create the impression that there is endless money available, we need to recognise what we are competing with in all the other Departments.

We are among the top three or four OECD countries in health expenditure. I would like all of our witnesses to comment on why we are so close to the top in terms of expenditure yet so close to the bottom in terms of delivery. We are not doing well in that pecking order. It is having a debilitating effect on health services in general at every level. If it becomes known nationally and internationally that we have a serious deficiency, we cannot deliver, and we are way down the ladder in delivering to patients, then nobody will want to work in that service. I agree on the filling of general practitioner posts but those posts have been done down over the past few years, although not necessarily by anything the general practitioners have done or failed to do. It has become the norm to say that they are underfunded and do not have the capacity to deal with the volume of patients in their areas. The volume of patients is increasing and the ageing population is against us. Incidentally, that is not all true. We have more young people in this country now than we have ever had. It has now been recognised, reluctantly, within the service that particularly in the greater Dublin area and the east, there is a huge number of young people in the system relative to older people. It is different in other parts of the country but we need to recognise this.

Which of the countries with which we are competing for staff and facilities has a system that is working the way we want ours to work? It is as simple as that. I am not a great believer in the HSE as a structure for delivering services at all. It is not possible to have a dual system such as we have with the Department of Health, on the one hand, dealing directly with people

and the HSE, on the other.

We were all informed that the purpose of primary care centres was to intercept the patient at an early stage and deal with those issues that could be dealt with at that level. I am not sure I have evidence yet that it is happening. I would like to see the evidence and hear more about it. We have systems within systems and we all seem to be competing with each other. The result is that the patient appears to wait longest. When a patient is told they must wait for a year, a year and a half or two years, he or she is dismayed. The patient's confidence in the system to deliver is gone straight away. There is no use waiting around for it. It just does not work. There is something wrong with the way we deliver the services and while there is a money element to it, there is also something else. Our systems are not interlinking and the various systems are not complementary to each other. They are working independently. Consultants will tell us that if they were looking for access to theatre, theatre staff or back-up services, they may not be available at the time they want them. As a result, the patient has to wait. It is not good enough.

We need to monitor pay parity. We need to compare our delivery of services with those who have better delivery of services while spending less money. Our own credibility, and my credibility as a public representative, are on the record when it comes to telling the public what they are supposed to do in those circumstances.

Senator Colm Burke: I thank the witnesses for their presentations and for their work. In the past three years, since January 2015, we have taken on more than 11,000 additional staff in the HSE. I understand that the numbers have gone from 99,000 to more than 110,000. However, that increase in staffing levels does not seem to have delivered any additional capacity. What are the witnesses' views? Was there a plan within the HSE as regards prioritising where people should be employed? Is it prioritising the areas that can deliver a better service?

I wish to ask the IMO representatives about the contract negotiations. We are talking about a contract that is more than 40 years old. Agreeing a new contract will take time. Could any element of the negotiations be expedited or fast-tracked to support GPs to deliver the service they want? If we can assist them, they can provide a better service which, in turn, will take the strain off other services within the health system.

Returning to the INMO presentation, Ms Ní Sheaghdha referred to the reconfiguration of the health service. What aspect of reconfiguration are they talking about? If that proposal has been given to the HSE, is it the case that the HSE is not responding or does not want to listen to outside bodies? For instance, I did a report back in 2012 on university graduates and final year medical students. More than 60% of those graduating that year confirmed that they intended to leave the country within 12 months. That was six years ago and we seem to have done very little to encourage people to stay. From the IHCA and IMO point of view, there seems to be a significant drain on doctors across all categories, including existing consultants who have been *in situ* for some time. Apart from the pay issue, there seems to be a serious morale issue in hospitals. Is this because of the structure of management? I was recently contacted by a consultant who had to take a decision on the management of a patient on a Sunday night. Three administration people were more or less telling the consultant how to manage the patient. I become concerned when I hear this is happening. Is there a problem with the managerial structure in the HSE and insufficient effort being made in training managers? Nursing staff, medical staff and care assistants go through a whole spectrum of training. Is the HSE providing enough training for managers to achieve the best possible outcomes in delivering services in the health system and ensure people work as a team rather than working against one another, which seems to be one of the problems?

With regard to pay comparisons, all the organisations referred to pay, which is only one reason for the difficulties we have in the health service. It would be useful to have comparisons showing the pay of nursing staff, staff nurses, junior doctors and consultants in other countries. It is important to have such comparisons. Very good presentations were made here this morning, many of which touched on pay but we have not seen comparisons with other countries. It would be useful to see what we are competing with.

The other issue is the ratio of doctors to nurses in the hospital system. I have not seen any comparisons of that ratio with other countries. A number of years ago, I had to attend a hospital outside Ireland for medical treatment that was not available here. It struck me that the ratio of nursing staff and doctors was much lower than in Ireland, whereas there were far more care assistants. Have we done comparisons with other countries? I am not saying we should reduce the number of nursing staff or doctors but we could get a better delivery of service using other people in other areas. Can we have some comparisons on that issue?

Chairman: I thank the Senator.

Senator Colm Burke: I have to go the Seanad because there is a health matter I have to speak on. I will be absent from the meeting for about 20 minutes.

Chairman: Would Ms Ní Sheaghdha like to kick off?

Ms Phil Ní Sheaghdha: Yes. I will start with the issue Deputy Murphy O'Mahony raised in respect of retention. We are on record and have been very vocal on the issue of retention being as big an issue as the issue of recruitment. There is absolutely no doubt in our minds that pay is the determining factor. We are not competing. We are not at the races. We have comparative figures which are compiled by our international colleagues in the International Council of Nurses. These compare, on the basis of purchasing power parity, the value of the earnings of an Irish nurse across Asian and European countries. When we compare with Canada, the United States, Australia, Japan, Denmark, Sweden and New Zealand, which are the main countries that recruit our members and nurses, we fare very badly.

Deputy Margaret Murphy O'Mahony: How do they compare with Ireland on pay?

Ms Phil Ní Sheaghdha: Average pay in Ireland is €32,718. The next lowest is New Zealand, where average nurse pay is €33,502. Nurses in New Zealand are going on strike for pay tomorrow. Being worse than New Zealand is not a good thing. In Sweden, average nurse pay is €34,025; in Denmark it is €37,537; in Australia it is €42,446; in the USA it is €46,834; and in Canada it is €54,536. The biggest area-----

Deputy Louise O'Reilly: I want to ask for a very quick clarification. Are the hours comparable? I just wonder about the hourly rate.

Ms Phil Ní Sheaghdha: The hours in Ireland are longer. Nurses in Ireland work a 39-hour week. In all of the countries with which we compared nurses work 37 hours apart from the UK where they work 37.5 hours. Deputy O'Reilly is correct that the hourly rate is less if one is looking at purchasing power parity. In other words, we have to work longer to get the income.

Deputy Margaret Murphy O'Mahony: Is the issue pay rather than conditions?

Ms Phil Ní Sheaghdha: Conditions will only be improved if we retain our nurses. The biggest problem we have is that when our members go to work there are not enough of them to

provide the service. This makes their conditions very difficult to work in and increases the incidence of burnout. This has been studied internationally and in Ireland as part of the RN4CAST. There is absolutely no doubt that staffing levels are inadequate to meet demand.

If I could combine that answer with my answer to Senator Burke's question on the issue of prioritising areas, it is fairly simple in our view. The comparison and staffing determinant for nursing is not based on the number of doctors but on patient outcomes. That is the model the Department of Health has accepted and agreed to implement. The problem is that the Department is not funding the implementation. We know from the study conducted over the past four years in four of our large acute hospitals, including Beaumont, Our Lady of Lourdes and Loughlinstown hospitals, that the outcomes for patients are significantly improved when a staffing ratio of 80 nurses to 20 healthcare assistants is put in place. The difference it makes to the mortality rate of patients is incredible. The agency spend and value for money are improved significantly because retention is improved. All of this is known to the HSE and Department of Health. The only barrier is that it is not being funded for implementation, which is a big problem.

When the number of consultant posts is increased and hospitals get busier, more nurses are needed to staff the additional workloads. In the funded workforce plan the HSE does not determine the staffing increase that will be needed for increasing services.

We have major problems in community care. We have already reached an agreement with the HSE, which is two years old, on expanding the role of the nurse in long-term care, step-down units and primary care. There is absolutely no reason in this day and age that patients should be transported from care for the elderly facilities to acute emergency departments to get services such as hydration or antibiotic therapy, which can be provided by nursing staff in those facilities. They are trained and qualified to do it. The problem is the process and procedure have not been built to allow them to do it.

In respect of other services, the community intervention team, CIT, model has proven to be extraordinarily successful in keeping patients out of hospital. It needs to be funded and expanded. The management of chronic disease is something nurses do in every jurisdiction. In Ireland, there is a long-held view that the management of chronic disease can be delivered outside of acute hospitals. We believe nurses are very well placed to provide that service. They are qualified to do it. They are expert in many of the diseases and chronic conditions that cause patients to be admitted to hospital, particularly respiratory conditions, diabetes and cardiovascular disease. The role and function of the nurse is an area we are happy to talk about and examine. We have reached agreements already which confirm that we will expand our practice. However, we are baffled as to the reason that is not being taken on and utilised as a cost saving and value for money initiative but it requires additional numbers, and that is the problem. We cannot get the numbers until we get the pay right.

On the VHI step-down initiatives, I would answer that question by saying community intervention teams are the way to go.

On Deputy Murphy O'Mahony's questions on funding local hospitals, she is absolutely correct that there are services that should not be centred in facilities such as Cork University Hospital. St. Finbarr's Hospital, which is one of the main facilities that takes patients from Cork University Hospital, advised us recently that it was cutting nursing staff numbers. We had to refer the matter to the Workplace Relations Commission, WRC, and go into dispute with the Health Service Executive, HSE. Those are nursing led services. They are extremely important

to keep patients out of the acute hospital and allow discharge to the acute hospital. They also allow general practitioners to admit directly to community hospitals such as Bantry hospital and other locations. Cutting staff in those areas is a short-term funding measure that makes no sense.

Regarding endoscopy, it is on the record that there is cross-party support for the Sláintecare report in respect of the availability of diagnostics outside the acute hospitals sector, which again is a matter that needs to be speeded up.

I think I have answered Deputy Durkan's questions on pay parity and who we are competing with. We have two problems with the recruitment and retention of nurses. One is that we are heavily dependent now on recruitment from non-European Union countries and have been for some time. Nursing was one of the grades subjected to the moratorium, while other medical grades were excluded. We are, therefore, still catching up from the posts that were not filled from 2007, which was when the moratorium was implemented in health. We are down 2,000 posts from that point, even though our hospital activity, as my colleagues in the Irish Medical Organisation, IMO, have pointed out, is way over 100 in most hospitals in terms of bed occupancy, etc.

We are recruiting from non-EU countries, from which other countries are also recruiting. When nurses acquire experience in a western environment like ours, the American and the Canadian markets come here to recruit them from us.

Deputy Bernard J. Durkan: Why are those countries also having difficulty recruiting?

Ms Phil Ní Sheaghdha: It is because there is a global shortage of nurses and midwives. It is a crisis-----

Deputy Bernard J. Durkan: Worldwide.

Ms Phil Ní Sheaghdha: Worldwide, and the countries that pay the most do best in respect of recruitment. We spend a lot of money travelling to India and the Philippines to recruit and we are very thankful that nurses from those countries come here and staff our wards because without them we would have very real deficits. However, what we are now finding is that health services in America, Canada and other countries are coming here to recruit and are succeeding because the packages they offer are very attractive.

Deputy Bernard J. Durkan: Why are they finding it difficult to recruit in their own countries if they are that good themselves?

Ms Phil Ní Sheaghdha: They are finding it difficult to recruit because they do not train sufficient numbers to meet their needs. In Ireland, we do not train enough to meet our needs. We train more than other countries when we compare but we still do not train enough. When we train nurses and midwives here, we do not do anything to retain them. The Minister announced last year that every graduating nurse will have a permanent contract but, unfortunately, the bureaucracy surrounding that means that England has recruited them before we have even interviewed them. It is a crisis. It is not something we believe is fully taken on board. We attended recently the national economic dialogue. We are very disappointed that health did not feature as one of the discussion points. Health should not be viewed as an area on which money is being spent without any return. Health is under-funded and reform is required but that reform has to be targeted in value for money areas such as those that nursing can bring to a service.

Advanced nurse practitioners have been the real benefit in emergency departments, EDs. Where advanced nurse practitioners are working we see numbers decrease. We are supposed to have a 7% ratio of our total nursing workforce at advanced practice level. That would require 700 advanced nurse practitioners. Currently, we have fewer than 300. This year, the HSE is saying it will try to fund 30. It is simply not enough.

Chairman: I want to allow other groups to contribute. I can call the witnesses again.

Ms Phil Ní Sheaghdha: I thank the Chairman.

Deputy Bernard J. Durkan: I mentioned the Middle East because there seems to be anecdotal evidence that medical staff go to the Middle East for a variety of reasons. Is that true or false?

Dr. Donal O'Hanlon: I do not have figures for emigration to the Middle East but I believe it would be a very low percentage. Most of our emigration is to English speaking countries, particularly Canada, Australia, New Zealand and, to a lesser extent, the USA. The salary differential is at least 40% - it is 60% in Canada and the USA - over the newly appointed consultant salary. We are uncompetitive with those English speaking countries that take by far the bulk of our consultant emigration. I have experience of trying to retain people we have trained and lost to Canada where they are paid twice as much.

Dr. Laura Durcan: I have some personal experience of that. I graduated in Ireland and did my intern senior house officer, SHO, registrar training here. I did two fellowship training courses in the United States. In terms of the contracts I was offered at the end of my fellowship training in the US, ultimately, I took my job in Ireland but I was offered twice as much money in the United States. That was for academic, four days a week posts and the salary would have been considered less money than I would have got had I gone into private practice in the United States, which was not something that interested me.

One of the centres I worked in was the Johns Hopkins Hospital in Baltimore, which is the number one centre in America. There are vast numbers of Irish graduates in the US, including friends of mine. When I went to Baltimore it was a big community of about 20 attending physicians or consultant equivalents and of those, I am the only person who has uprooted to come home. The general consensus among them would be that I was mad to consider leaving. These are people who are publishing in the *The New England Journal of Medicine* and developing medicine in an amazing way. They are incredibly clever and engaged and we have lost them; they are gone. Unless the position improves here they will not come back, and they would be an amazing asset to our health service. It makes me sad that they will not come back here unless the terms and conditions we work in improve.

Dr. Donal O'Hanlon: The situation has changed radically since I returned home. When I competed for a post in Ireland in 2009 there were over ten applicants for my post. We are lucky now if we get more than one. In fact, we close many competitions because we cannot get applicants.

Deputy Bernard J. Durkan: What is the primary factor in that respect?

Dr. Donal O'Hanlon: The primary factor is the pay disparity. We have fallen so far behind in the past ten years we are not competitive. In addition to that, there is a gulf between the salary paid to newly appointed consultants here and those paid to newly appointed consultants anywhere else in the English speaking world.

Chairman: I thank Dr. O'Hanlon.

Dr. Peadar Gilligan: To answer Deputy Durkan's specific point about pay parity, and this not being the location to negotiate that, I accept he believes it is correct that people should be paid equally for taking onerous jobs with a huge level of responsibility. However, it was a political decision to subject appointments to a consultant position from October 2012 onwards to a 30% cut. That was only partly ameliorated by the efforts of the IMO regarding new consultants, with a slight uplift from 2015. That agreement has resulted in a doubling of the time it takes to reach the top point of the salary scale. Now, with the recent settlement that was an acknowledgement of breach of contract, we have a situation where that disparity has been increased again, as Ms Clyne has pointed out. Until that is addressed, we are not going to be able to recruit people to consultant positions in the numbers we need. We are going to have situations where we advertise for the most senior positions in our hospitals but attract no applicants. We are going to have a situation regarding the morale of newly-appointed doctors. Instead of being at their most productive in their first five years as consultants, they will be feeling utterly demoralised by the fact they are not being paid at the same level as someone else doing the same job. It was a political decision. It is a political imperative that the decision be reversed and that we treat all consultants the same way, because only when we do that will be able to address the recruitment and retention issue.

Deputy Bernard J. Durkan: I agree in the context of the political decision but, as we all know, it was taken out of necessity. Otherwise, the country would not have survived. Everyone was affected by it.

Dr. Peadar Gilligan: In that regard, I point out that every other new entrant level had a 10% cut. Consultants faced a 30% cut. What happened was vindictive, and that vindictiveness has resulted in a situation whereby patients throughout the country are being left without consultants. That has to be addressed.

Ms Susan Clyne: I want to make a couple of general points in response to some of the questions. We talk about the fact that the spend on healthcare is increasing without ever discussing the population, healthcare needs and what is being delivered. The spend will increase, but our spend is not even keeping pace with demand. In respect of the elderly, I accept the point with regard to the number of young people and people along the east coast. However, the point we are trying to make is that percentage of the population aged over 65 is increasing rapidly. This is not in any way to blame the elderly for using resources, it is to recognise the current needs and the future demographic needs of that population in the context of our health service.

Deputy Bernard J. Durkan: I apologise for interrupting again. The population has increased. That is correct and it means we have to increase our spend. The fact is, however, that, in comparison with other OECD countries, our level of expenditure is already fairly sizeable. It is not at the bottom of the scale by a long shot. My question was whether the witnesses can give us some indication as to why our delivery of services to patients is behind that in other countries that spend less. That information would be helpful to us in the course of what we are trying to do.

Ms Susan Clyne: There are a number of factors. One is that we are coming from ten years of underspend. That takes time to get it right. There is also the model by means of which we deliver our health service, which is costly. Some of these issues are addressed in Sláintecare and also in the health capacity review. Healthcare costs money and we do have to accept this. More complex healthcare costs more money. As technologies change and drugs and new treat-

ments become available, they will cost money. We should not be driving for our healthcare costs to be reduced. We should spend money appropriately but the model of care must change. We must also recognise that we have had ten years of no service development, a growing population and more complex care. Those who work in the health service have delivered incredibly good work in very difficult conditions during this time. This needs to be acknowledged, and it is not acknowledged very often.

Mr. Martin Varley: The big issue with regard to recruitment is whether we are competitive. We have to be aware of what is happening in the marketplace. There are a number of indicators on this and they have been commented on by Dr. Durcan. If we look at what we pay for agency doctors to fill consultant posts it is in the region of €250,000 to €350,000. It is a false economy to perpetuate what I describe as the discrimination. We are far better off investing in permanent young consultants. It will provide a better service and continuity of care. It is a misnomer to describe new consultants as new entrants to the health service. In general, they have ten years or more experience. They are highly trained and they should not be subjected to a new entrant salary reduction of any description. As has already been stated, the reduction was extreme at 30%.

If we subject a group to a 30% reduction and do not reverse it when the economy improves, it is not surprising that there will be serious problems with recruiting and retaining. Today, for example, there is a pay differential of approximately 57% between a newly-appointed consultant and somebody appointed prior to October 2012. People do not realise the extent and extreme nature of this. This gap will widen and increase, possibly to 70%, in the coming years. If we do not arrest the problem quite soon we will lose a generation of highly trained specialists. That is our primary concern. I do not think we can afford to be in that position. The health service will suffer significantly as a result. Dare I say, medicine in Ireland could become a backwater if we do not keep up with the pace of change in medicine and surgery.

Deputy Durkan referred to numbers and expenditure. On the basis of the OECD figures across the board in health, Ireland seems to be one of the highest spenders. We discussed this at a previous meeting of the committee. When we look at acute hospital spend, we are somewhere in the middle of the OECD pack. We are not at the high end because we have not been investing in acute hospitals. The number of beds is lower and the occupancy is very high. We have a lower number of consultants on a population basis. We have almost the lowest number in the OECD in that regard.

It is important that we segment out the spend and look at what is happening in this regard. The Deputy rightly asked the question that if the total pot of spend is big how come we do not get the benefit of it and where are we going wrong. A geo-alignment review is being undertaken and we suggest that it may provide some of the keys to ensuring improved effectiveness. It defies logic to have, on the one hand, hospital groups with separate management and separate budgets and, on the other, community health organisations with separate management and separate budgets. Not only should they be geo-aligned they should be merged. If we were looking at this in the private sector we would merge them, and have one set of management and one budget and a fully co-ordinated linkup between hospitals and the community. We would have some hope of getting synergy and improved efficiency in this regard. We highly recommend this. It is hugely important.

Let us not lose sight of the fact that in our acute hospitals, despite the fact we have approximately 1,400 fewer inpatient beds, we treat approximately 250,000 more patients than we did in 2009. That is a difference of approximately 20%. A lot has been achieved in very difficult

circumstances. If, however, we do not recruit and fill our permanent posts, we will be in a very difficult position.

Chairman: I will bring in some other members and we will come back to some of the unanswered questions later.

Deputy Stephen S. Donnelly: I thank the witnesses for their time. Having listened to the exchanges for the past two hours, I have to confess that I am thoroughly depressed on behalf of the good people of Ireland because, as has been laid out, the witnesses have dedicated their lives to healthcare but patients are suffering. Much of the time, patients and staff are going through completely unacceptable situations in many emergency departments. Regularly, patients and staff in acute settings are in completely unacceptable situations. When patients are trying to be discharged from the hospital they cannot necessarily get an appropriate step-down facility. If we want to move them back into their homes they cannot necessarily get the home care package or the home care hours they need. We have a crisis.

The IMO represents GPs, but we have not really been speaking about the latter today. They say they are in crisis. Our GP and primary care sector is in crisis, our acute sector is in crisis, our emergency departments are in crisis and patients are suffering, as we all know, every day.

The reason I am depressed is that obviously there is very little money. I heard solutions from the INMO that do not involve more pay. Obviously, its representatives focused on pay as well but they have laid out solutions that do not involve more money, just running the system properly and making the HSE a desirable entity for which people will want to work, regardless of pay and regardless of their colleagues in Johns Hopkins Hospital. Perhaps they will get a pay cut coming home. However, they will be excited about returning because there is a wonderful academic centre of excellence they can come to where they can invent wonderful new treatments.

I took a look at pay and examined data from the OECD and various data sources around the world. What is happening is perplexing. Starting with doctors, numerous sources say our doctors are still some of the best paid in the world. They are not the best paid and we are no longer in the top three countries. However, we are in the top ten. The problem is that the other English-speaking countries they can go to, such as Australia, Canada and America, pay more. That does not necessarily mean that we should pay our doctors more than any other country in the world. We cannot compete with American pay scales. We never could and we never will. That is not the value proposition when it comes to the Americans. Australia is trickier. It is paying a great deal of money and the nurses and doctors I have spoken to say it is a great place to work. It is also warm more often than it is warm here. It is a tricky place with which to compete. The same is true of Canada. It gets snow and sun. However, the reality is that our doctors are not badly paid, but well paid. Yes, they have taken an unmerciful hit. They were extremely well paid and now they are just well paid. I reiterate that we are still in the top seven in the world.

Matters are also tricky when it comes to nurses. As the INMO correctly pointed out, the nurses are badly paid relative to other healthcare professionals of similar education. Relative to private sector new entrants, however, they are very well paid as new entrants. When it comes to a nurse versus an engineer, the private sector pays engineers, architects, lawyers and other professions that require a degree significantly less than the public sector. I also took a look at nursing salaries around the world. In 2013, nurses in this country were the third highest paid. We were still in the top five countries in 2016. I have looked at multiple data sources and all of them say that Irish nurses are among the best paid in the world. I have looked at the various

career sites and, in each case, Ireland is in the top ten. There is something that has to be figured out there because, looking at it without having knowledge of what Irish nurses are dealing with, it appears that our nurses are pretty well paid. Our doctors also appear to be well paid. However, there is a strong feeling among the nurses and doctors that they should be paid far more, and that the reason they are leaving the country is that they are not paid more. That is something we will have to figure out.

Deputy Durkan asked the question I also wish to ask. I fundamentally disagree with the earlier statements about chronic underinvestment in healthcare in Ireland. The data simply do not show that. In fact, they show the opposite. This country invests more in healthcare than practically any other country on earth. Again, the Americans are out on their own, but that is because of utterly dysfunctional system issues relating to private health insurance. It is not the type of healthcare system I would like. It is a great healthcare system if one can afford it, but America is not a good country in which to get sick if one is poor. It is not true that we do not invest in healthcare. The data are unambiguous. We invest shedloads of money in healthcare whether one assesses it by percentage of GNP, purchasing power parity or investment per person. In addition, our people are much younger than those in most other countries, so if one does an age adjustment, we spend more on healthcare in this country than anywhere else on earth except America. We invest a vast amount of money in healthcare. Perhaps we should pay even more but relative to other countries we pay our clinicians quite well. In every data source I can find, we are listed in the top ten around the world. That is not bad. Clearly, it is not enough for the doctors and nurses, but it is not a small amount of money.

I wish to push further on this. If we are spending more money on healthcare than virtually anybody else and we have a GP sector that is falling apart, emergency departments that in many cases on a Friday or Saturday night are simply not okay for either patients or staff and we have 95% occupancy of beds and so forth, where are we wasting money? Clearly, we are wasting vast amounts of money somewhere if we are spending so much and our clinicians are so annoyed that they are leaving the country to work in other places. We must be wasting billions of euro every year which we should be investing in drugs, doctors, nurses, beds, GPs and primary care but which we clearly are not doing. The witnesses all work in the system so they can help us find the money. Where are the billions that we should be pulling out of some parts of the system and reinvesting in the people the witnesses represent? That is my first question.

Second, can the representatives of the three groups give us the top two cost neutral things they would do immediately, be it for capacity, their members or whatever? I will briefly give the framework for this. The fiscal space is €800 million. Different political parties have different interpretations of it, but that is the one that Fine Gael and Fianna Fáil accept. There is €800 million available. The confidence and supply agreement provides for a 2:1 ratio on tax and spend. I believe that is wrong because I would not reduce taxes at present, but that is not my call. However, if one does what is in the agreement there is approximately €550 million left for investment. If one pulls one quarter of that for health, which is the *pro rata* amount spent on health as a percentage of the total spend in the country, there is about €150 million. That does not include healthcare inflation so we can knock off another €80 million for that. Before we start there is approximately €70 million available in the budget for new things. To put that in context, Sláintecare in year one requires approximately €1 billion. What are the cost neutral measures?

Third, what are the investment priorities? Do they include pay? The witnesses have laid them out but what is the first priority? Is it 10%, 15%, 20% or 25% more pay? Is it hiring the

extra doctors and nurses that are needed? Which of those would come first or is there something else? Is it implementing the eHealth agenda or fixing the numerous HR issues which doctors and nurses face every day and which drive them crazy? Given that there is very little money available if we comply with the European guidelines on budgets, where is the first place the witnesses would spend the money in terms of wages, more staff or elsewhere?

My final question is a technical one for Mr. Varley. He spoke about the 57% to 70% gap between new specialists - they are not new entrants - and old specialists. Can he give the euro figures for that? What is the starting salary for new specialists and what salary he is comparing that to, which is 57% to 70% higher? Mr. Varley said that while our total healthcare spend is very high by international standards the spend in the acute sector is mid-level. I am not denying that is the case but, if so, we must be spending vast amounts of money somewhere. Obviously the acute sector sucks up a great deal of the money so if we are at medium level in that sector we must be at the top in other places. Does he know what they are?

Deputy Louise O'Reilly: I welcome the witnesses and thank them for their presentations and all the work they do representing their members. I wish to clarify one point. It is fair to say that GPs are represented here, although that is not necessarily the subject we are discussing. Their representatives are in the room. Perhaps representatives from the IMO might like to say something about GPs.

The HSE appeared before us last week. I am sure the witnesses will have looked back on it but in case they did not, it had a wonderful idea for increasing the number of staff. It is just going to change how it counts them so student nurses that were previously counted as 0.5 WTEs at one minute to midnight on 31 December turned into full WTEs on the stroke of midnight. If it was able to do that with all of its staff, it could indeed double the number overnight. I do not think that is a very productive thing to do. It did not have any explanation as to why it had done it - merely that it was on the recommendation of some person who did not happen to be in the room.

On the Public Service Pay Commission, pay for front-line healthcare workers is an issue I have raised virtually all of my working life but certainly since I became a Deputy. The latest reason for not answering our question is that the Public Service Pay Commission will deal with that. The commission's report is due at the end of this month. I think it is pretty much irrelevant where someone's profession is positioned on a table, particularly as we are haemorrhaging staff to countries that pay more. However, let us imagine that the Public Service Pay Commission does not adequately address the pay issues outlined by the witnesses. Could they provide a picture of what our service will look like come winter? My contention would be that we are not well prepared for winter. Indeed, we managed to be surprised by the flu last winter. In the event that the pay issue is not addressed, are we looking at hiring more agency staff or closing more beds? What will be the implications of this? My estimation is that the Government is putting a lot of emphasis on the Public Service Pay Commission. If the latter does not deliver, we will find ourselves in a very difficult position. I would welcome the witnesses' views on that matter.

When representatives from the HSE appeared before us last week, they also put it to us that people do not want permanent jobs. They referred to nurses in particular. Dr. Durcan is smiling. I also smiled because it struck me that people did want permanent jobs. It cannot just be my mother who raised me to want a permanent job. I am sure everybody's mother wants him or her to have a permanent job. People themselves want the stability of a permanent job. Senior people in the HSE told us that new and prospective entrants to the health service are actually running away from the notion of a permanent job so could the witnesses comment on that?

In the context of the funded workforce plan, which I know relates specifically to nursing, could Ms Ní Sheaghdha bring us up to speed? When is the plan likely to be published? What would be the likely implications if it was, for example, published in the morning? If there is a six-month lead-in time for the recruitment of staff, where does that leave our graduates now? Are they actively involved in a recruitment process? I know it is warmer in Australia and other countries and that some places have sun and snow, but they had that ten years ago and temperatures have not changed dramatically. That is not me denying climate change. I just do not think it has changed dramatically. Yet we did not have those sort of problems ten years ago. My understanding is that young people with portable qualifications went abroad, worked for a year or two and came back. Why would they not do so? They are not coming back, however.

Those are some of the issues on which I would like the witnesses to comment. Retention is a bit of a chicken-and-egg thing. We are losing staff because it is an unattractive place to work, which means we are not recruiting staff, which makes it a more unattractive place to work, which means we are losing staff. In terms of initiatives to retain staff, is there anything at the moment that might be working in one hospital? Let us say there is a particular hospital that is managing to keep its staff. Is there anything that one hospital is doing that could be modelled across the health service? I am not convinced that there is but if there is, we would welcome that information because it strikes me that this is a double-edged sword. The failure to recruit is leading to pressure on retention. There is a lot of talk about new entrant pay and how poorly new entrants' pay compares with that of other jurisdictions but, equally, we have an issue with retention. Is that purely pay-based? I know it has to do with the conditions. One feeds the other. Are there initiatives that could be taken that would improve retention?

I would also like to hear the witnesses' view on the actual number of beds. If we clicked our fingers or used the magic formula the HSE used and doubled our staff overnight, are there sufficient beds in the system? My estimation is that there is anything from 500 to 1,000 beds that could be opened relatively quickly if we had the staff. I would welcome the witnesses' views on that.

Regarding the conversion from agency staff, I am sure the witnesses are aware, through the media, that Sinn Féin recently published figures in respect of the spend on agency staff and the manner in which it is increasing. When I raise this, the Minister then tells me that a whole raft of wonderful initiatives is in play. There is a heavy focus on converting from agency staff to directly employed staff. Can the witnesses give us some estimation of what, if anything, is happening with that and what could be happening? Clearly, these people are available to the system but they are choosing to either remain registered and work with agencies, work on a half-and-half basis or work full-time for the HSE and then part-time for an agency in order to supplement their wages. It could also be the case that there is not much effort, from a managerial perspective, regarding how the process of conversion is going.

Obviously, the people who are here represent a large cohort of the workforce within the health service, although not the full cohort and not every worker. It is proposed that at a later date, and I say this for the benefit of anyone who might be looking in and thinking "Hang on a second, I am not one of those grades. Why am I not represented there?", we will come back to this issue and there will be an opportunity for all of the grades to make a presentation.

Chairman: We will bring in witnesses from the IMO first to comment on some of those issues.

Ms Susan Clyne: I will set off and then Dr. Gilligan will come in. Regarding the numbers

quoted by Deputy Donnelly in the context of where doctors are well paid, nobody suggested doctors are not well paid. What they are suggesting is that we are not competitive with the market so what a consultant is paid in France, Germany or the Netherlands is irrelevant. Irish doctors are not going to these places. In the main, Irish doctors are going to Australia and Canada and, in some cases, the US. There is a global shortage of doctors and nurses and we just have to face up to that fact. We are competing in a market. In respect of the data sources shown by Deputy Donnelly, maybe they are earning more but it involves different systems. It is not like comparing apples and oranges. There is a significant issue - not just pay, which is a huge differential.

To answer Deputy O'Reilly's question, there are other reasons why people are driven abroad. It is not just because of the weather. They are driven abroad because they can work. If a person is a trained surgeon, he or she has theatre time. He or she can see patients and refer them for diagnostics. he or she can do his or her training. In almost all these other countries, including Canada and Australia, it is a four-day week that involves seeing patients and being able to refer them on for appropriate testing. It is about getting results back quickly. It is not about seeing a patient and telling him or her that one will see him or her again in a year or two. It is also about huge support for doctors' continuing professional development. For example, Australia has a grant that allows doctors to do their training and continuing professional development. They are supported to do that within the working week. So there are a lot of things happening in terms of recruitment and retention.

Regarding the population, the point we are trying to make concerns investment in healthcare. It is not that we do not spend a lot of money on healthcare; it is that we do not invest a huge amount in new service development or in the things we need for the future. We do not plan and invest for plans to be implemented. We are talking about a fiscal space of €700 million or €800 million. If Sláintecare is not going to be funded, it behoves politicians to stop using it as the plan that will help the health service. If we need €1 billion to fund it in our first year, the public should not be told Sláintecare will happen if that €1 billion is not there, and that is a real difficulty. There are huge patient expectations and people in the health service work really hard every day to deliver on those expectations. Pay is a big issue. There are other issues such as investment. People want to be able to work in theatres. This requires resources. Almost everything costs money but one way in which we spend money inappropriately in our view is through the National Treatment Purchase Fund, which is a short-term measure, and through agency staffing. If the numbers were looked at in the long term, it would probably be discovered that the conversion of agency staff is cost-neutral.

In response to Deputy O'Reilly, there is no big shift or move to convert staff from agency to permanency, and the staff have no real desire to do so because the people who come in on agency work earn more than the permanent staff, choose their hours and do not all reside in the jurisdiction. I therefore do not believe there is any big move happening in that regard.

The Public Service Pay Commission was part of the public service stability agreement last year. Many organisations and unions, including us and the nurses' union, signed up to the agreement on the basis that it would deal with the recruitment and retention issue, which - there is no point in pretending otherwise - will cost money. One thing we are a little anxious about is the idea of picking the top thing and investing in that top thing. We have learned over many years and all the reports show us that if we do that, that is, if we start focusing on one thing in health, something else will break down. We must invest the money across the board and then see where we are. If the plan is going to be Sláintecare, the money should be invested in it. We

have objections to some of the areas of Sláintecare.

Deputy Bernard J. Durkan: I am sorry to interrupt. I have just a quick point. Waiting lists are not a new phenomenon in this country. There were waiting lists ten, 15 and 20 years ago. What I am a little concerned about is this: we do not seem to have come up with a model that allows for a free, rapid flow of people through the system. I was one of those who called for the reintroduction of outsourcing because the waiting lists had become intolerable. Scoliosis is a classic example, whereby people are urgently waiting for treatment. What do we do? It is a little like the housing lists. The people on the front line of dealing with the housing lists tell us we must house the people who have been on the lists for ten years or more. What, then, do we do with the people who are out on the road now? It is the same with the health services. The people who are acutely in need of services and responses now cannot wait for two, five or ten years, depending on the particular requirements. They cannot wait at all.

Chairman: Deputy, just-----

Deputy Bernard J. Durkan: I am sorry, Chairman, but this is not rocket science, and we are not addressing that part of it at all. It is not all about money; it is about organisation as well. It might not be the Irish Medical Organisation's problem; it may well be the fault of the HSE, which I have blamed, as the Chairman knows, for being inept and ineffective. That is the way it is-----

Chairman: Thank you, Deputy Durkan.

Deputy Bernard J. Durkan: -----but, unless we soon deliver to the public, the Chairman and I, as public representatives, will also become obsolete, and that is a serious problem.

Ms Susan Clyne: I wish to respond to that.

Chairman: I ask Ms Clyne to make a few final remarks, and then I will bring in the IHCA.

Ms Susan Clyne: Waiting lists have always been a feature of the Irish health service. However, the waiting list problem now is huge, with over 700,000 people on waiting lists. Capacity is the issue. In the same period in which those waiting lists grew, the system took out 1,600 beds. It did not increase its medical workforce.

Deputy Bernard J. Durkan: There were those who suggested taking out more beds.

Ms Susan Clyne: There were - not from the IMO, let me tell you.

Deputy Bernard J. Durkan: In the medical profession.

Mr. Martin Varley: I will attempt to answer Deputy Donnelly's very direct questions, which are extremely important. First and foremost, regarding our spend and how it compares internationally, the Deputy is correct. We spent approximately €4.5 billion out of the €15 billion or so on acute hospitals and mental health services, so let us say approximately one third. Our analysis shows that we are in or around the middle. We are not overspending; in fact, we are probably underspending. The indicators are there: the beds, the occupancy and the low number of consultants. Where is the slack, then, for want of a better term? Part of this goes back to our infrastructure and organisational structure. The whole service has evolved through a series of reconfigurations and reorganisations. This exercise has not been carried out in a fashion that is reflective of what would happen in the real economy in terms of-----

Deputy Stephen S. Donnelly: Is that a polite way of saying there are too many administrators?

Mr. Martin Varley: I was just coming to that. The OECD figures and the figures for the Irish health service show that we have, relatively speaking, a lower number of doctors than in other health services and higher numbers in other grades. This could be in administration, management or other areas. There is scope to look at this and probably gains that can be achieved. Is this dependent on restructuring the service? Yes, and I refer to geo-alignment in this regard. Geo-alignment on its own is not enough. The CHOs and hospital groups need to be merged; otherwise, we will not take out the layers or deal with the lack of effective communication and co-ordination. The Deputy talks about step-down care and home care services. If there are two groups and two separate budgets and everyone is trying to stay within his or her budget, dysfunction creeps in. We therefore need the one CEO, the one management structure. Then there would be hope of streamlining and more effective co-ordination. There is scope there. Where else do we have a higher spend? Our drugs bill is, relatively speaking, higher in international terms. From memory, we are talking about a €2 billion drugs bill in the service, so again, there is scope there.

Going back to the Deputy's questions of comparing how well paid doctors and consultants are, we are in a transitional stage whereby the discriminatory salaries, to which we referred, being paid to the newer consultants do not reflect in that comparison because we are talking about 10% to 15% of the total. The Deputy asked me what the differential is today. The differential today for a new type A consultant is approximately €76,000.

Deputy Stephen S. Donnelly: What do they start on?

Mr. Martin Varley: They start on €134,000 and are €76,000, or 57%, below their comparators appointed prior to October 2012.

Deputy Stephen S. Donnelly: Sorry. I ask Mr. Varley to bear with me. A new specialist today-----

Mr. Martin Varley: A new appointee, yes.

Deputy Stephen S. Donnelly: -----will earn €134,000-----

Mr. Martin Varley: That is the starting point.

Deputy Stephen S. Donnelly: -----but they used to earn €210,000. Is that right?

Mr. Martin Varley: They are working alongside colleagues who are being paid €211,000 as of-----

Deputy Stephen S. Donnelly: I just want a like-for-like comparison because the phrase "working alongside" suggest that their colleagues are more experienced. Can Mr. Varley give me a like-for-like comparison in terms of time served as a specialist?

Mr. Martin Varley: That is never done because we are talking about recently appointed-----

Deputy Stephen S. Donnelly: What were new specialists paid? What was the starting salary for a new specialist?

Mr. Martin Varley: The starting salary would be in the region of what they are being paid

currently. Historically-----

Deputy Stephen S. Donnelly: What is that?

Mr. Martin Varley: -----there have only been three increment points on the scale. Why? In order to compete internationally, one needs to be able to bring people in at a relatively high salary. Traditionally, we have not had a long scale because we needed a focused scale to compete.

Deputy Stephen S. Donnelly: Just so I am clear, then, the entrant salary used to be €211,000 and it has dropped to €134,000. Is that right?

Mr. Martin Varley: Yes, so the difference is 57%.

Deputy Stephen S. Donnelly: What is the 70%?

Mr. Martin Varley: As time goes on, as FEMPI is reversed, this gap will actually increase. The differential will become bigger. Unless we address the discriminatory salaries for new entrants, there will be a bigger problem.

Deputy Stephen S. Donnelly: What will the €211,000 go back up to with FEMPI reversed?

Mr. Martin Varley: Based on the 2008 contract, it is to go to €252,000 for type A public-only contract consultants. For type B consultants, the difference is approximately €66,000, 52% currently. This will increase to approximately 70% if the discriminatory salary scales are not corrected. To put it very simply, the message we are sending out is that to be competitive, we need to start to pay the new entrants what was included in the contract agreed by the Minister for Health in 2008. A decade later, as we are not even paying the new entrants anything approaching what was agreed in 2008, it is not surprising we are not competitive. That is the first point.

The second point is if one has a differential of the order of between 50% and 60% and one is asking people with ten or 15 years' experience and fellowships from the US and wherever else to come back and work alongside a colleague where there is such a differential in salary, it is not surprising that they are not showing interest in the posts. It is discrimination in the extreme. We are not talking about the 10% differential that came in in 2011, this is of another order of magnitude and it is in a profession and in a grade whereby we have always suffered in trying to compete and fill posts.

The other thing to add is that, relatively speaking, we have a lower number of consultants on a population basis. The job is somewhat more onerous. One could be on a one-in-three or a one-in-four on-call roster. If one was in another jurisdiction, one might be on call one in 15 or one in 20 weekends in a year compared with one in three or one in four or five. All of those things come into play and as we said earlier, if there is a difficulty getting resources to treat patients, that is an added difficulty for consultants coming in. New consultants are always competing trying to find a resource such as theatre operating slots, bed space for patients and whatever else. There is a whole cocktail of issues coming into play but we would say we have to end the discrimination to be in a position to compete and get these highly trained specialists back. That is what I have to say on the salary issues.

I cannot leave out the number of beds and the fact we do not have adequate capacity in the health service. This is the perennial issue that keeps coming back to us over recent decades. We have cut the beds when we should have been increasing them. Now we are quite concerned.

We have a national development plan with funding for 2,600 beds but I do not see any serious intent in the system to put in place an annual commissioning plan. We are in crisis mode and if one is in crisis mode with beds and trying to get patients off waiting lists and off trolleys, the first thing one should do is to have an annual commissioning plan. I hear nobody in the health service management talking about that.

Deputy Bernard J. Durkan: We have asked the people to quantify the precise deficiencies in capacity at each level. We cannot make a major contribution to this debate unless we know that, and we must find out soon.

Mr. Martin Varley: To add to what Deputy Durkan has said, the capacity review was commissioned and delivered earlier this year. The national development plan built on that and provided the funding. What we are asking for now is an action plan so that we will know we will have X number of additional beds each year in the future. Based on historical performance, it takes up to seven years to commission and put in place a bed in the health service. If we do not get the annual commissioning plans at this point we will all be retired before we see any real exercise of putting beds in place, at a time when we have 700,000 patients waiting for care.

Deputy Louise O'Reilly: Could I refer to one of the questions I asked? On the number of beds, in the short term, with adequate staffing, are there beds currently in the system - without having to engage in the commissioning process? I am talking about reopening beds that were closed. Are there beds in the system that we could put our hands on now or in the short term?

Mr. Martin Varley: I am sure there are. Part and parcel of recommissioning those beds is having the resources to staff them. When I ask for an annual commissioning plan I am asking for the infrastructure piece and the staff to deliver it. This is the real gap in terms of our thinking. We came up with a bed capacity review and then we came up with a national development plan but I do not see the follow through.

Deputy Louise O'Reilly: As the people who drafted the bed capacity review were explicitly told not to look at a staffing plan, one would have to wonder what was going on there.

Chairman: I am going to bring in Dr. Gilligan, whom I omitted, and then Ms Ní Sheaghdha.

Dr. Peadar Gilligan: First, I will touch on Deputy Donnelly's points. He referenced that he finds this depressing. Can he imagine how I feel as a consultant in emergency medicine who has been working in the system now for 14 years, and who from the start of my career has been trying to address the overcrowding of emergency departments and who still experiences that on an all-too-frequent basis? What that means is that patients who need to access hospital care in this country are subjected in emergency departments around the country to an average of about 14 hours before they will get into a ward bed. The reason for that is the lack of capital infrastructure, beds and staffing that we have.

To respond to one the Deputy's final points, which was what we can do on a cost neutral basis and what would our number one priority be, our number one priority has to be facilitating our doctors and nurses to provide patient care. We do not have a system currently that is doing that. The reason we do not have it is because we did not have enough beds in the system 14 years ago when I started. We then took beds out of the system and we have not put enough back into the system. As a matter of absolute urgency, we require 1,500 beds now and we need to move more towards the 7,000 end of the capacity assessment done on behalf of the Government with regard to the requirements over the next 15 years or so.

Deputy Stephen S. Donnelly: Could I ask Dr. Gilligan specifically about the 1,500 beds? I want to test that a bit. The one hospital group where the waiting lists are coming down - in some cases to zero - is the RCSI hospital group.

Dr. Peadar Gilligan: Yes.

Deputy Stephen S. Donnelly: I looked into what it appears to be doing differently. What it appears to be doing differently is its admission from emergency department to the ward is substantially lower than the national average. That may be because it is case mix adjusted but it appears to have figured out in a focused manner the people who really do need to be admitted and those who can be sent home or back to community-based care and that puts less strain on the system.

One of the other things the group tells me it is doing is pushing the approach that when a patient is discharged, he or she is discharged to a care package in order that the patient does not arrive back with pneumonia again, for example, in the emergency department three weeks later and off we go again. In doing that, it is taking the strain off the system. It is interesting in that I have spoken to some of the clinicians working in some of the RCSI hospitals and some of them are telling a different story. They are saying that things have got a lot better around here; things have got a lot calmer, that they have more capacity, and they are being facilitated in working as doctors and nurses because of these things that have happened.

I do not know what the answer is. I am asking the question because obviously this is Dr. Gilligan's life, but there is an argument when one looks at the figures and when one looks at what the RCSI hospital group has done and how it has done it that says perhaps the solution is not 1,400 or 1,500 new beds, perhaps it is really good admittance practice from emergency departments and more beds in emergency departments. There are obviously choke points such as resuscitation beds or intensive care unit, ICU, beds in terms of patient flow where that is a clear blockage. More home care packages are also required. What is Dr. Gilligan's sense on that? Since I have come into this brief what I hear all the time is that we need more beds. I am not talking about for population growth. That is taken as a given that we do for the future but I have heard two different views from clinicians and managers. Some say we need more beds and others say we may not need more beds, we may need to provide very targeted emergency department beds, ICU beds and resuscitation beds, admissions practices and step-down beds or home care packages. What is Dr. Gilligan's sense on that?

Dr. Peadar Gilligan: First, I absolutely acknowledge that things have improved. We have gone from an average over that 14 years from 21 hours waiting for a bed to 14 hours waiting for a bed. It is a very significant improvement but it is not good enough. My colleagues in the RCSI hospital group have worked incredibly hard to achieve that reduction in length of stay for patients requiring admission from the emergency department and to introduce some of the initiatives Deputy Donnelly mentioned. We acknowledge that the ability to move patients from long-term care in the hospital to nursing home care has improved our access to bed availability. It is fair to say we have gone from having 15% of our bed base occupied by long-stay patients at any given time to half that rate. That has involved a huge amount of work. We have a group in the hospital dedicated to ensuring patients are moved through the system and on to nursing home care, augmented home care packages or other such arrangements, as appropriate.

Considerable work was done on trying to reduce the length of stay of patients. That has included trying to accelerate the investigations done for patients. It has included trying to accelerate access to services such as MRI, CT and ultrasound scanning. There has been a huge

input by the clinicians on call, who are now rounding two or three times per day to try to ensure patients get through in a timely manner. However, I have yet to meet a clinician in the RCSI group who tells me it is not a bed issue. We all know we do not have the capacity we need.

In Beaumont, there was an assessment some years ago by auditors from the NHS who advised that, given our current workload, that hospital alone needed 250 additional beds. That was just one hospital in the system. Therefore, we absolutely need hospital beds. I have patients for 14 hours. The 14 hours are usually a good seven or eight hours after the decision to admit has been made. The reason I have the patients for 14 hours is that there is no available bed at the time to put them into. That is because Beaumont Hospital runs at about 104% occupancy. Approximately 6% of that 104% is in the emergency department. Yesterday evening when I left our emergency department, which has 24 clinical spaces, there were over 60 patients there. Most of them were going to be going home, having undergone assessment, investigation and treatment. For the 24% who required admission, there was going to be a wait for more hours before getting a hospital bed. That is because we do not have enough beds in the system.

To be absolutely clear, the issue of crowding and overcrowding in Irish hospitals is significantly worse than in any other developed country in the world. It is worse because of our capacity issues in the system. Those are not just around the beds. The beds are a considerable issue, however. Until we get the beds right, we will really continue in the storm.

To answer Deputy O'Reilly's question on what this winter will be like, bearing in mind the fact that we need 1,500 beds now, unless there is a very significant increase in existing capacity by approximately 600 beds, it is likely that there will be considerable numbers of elderly patients in every emergency department in the country waiting for a significant period to gain access to a hospital bed. We will have staff traumatised by the compromised care they are having to deliver because they do not have the space in which to deliver it.

We have heard about the fiscal space many times. Space is something I would love to have in an emergency department to provide care, rather than having to wedge myself between trolleys when taking a history and trying to assess patients. We will get that space only when we have the beds, the medical and nursing staff and allied health professionals to help to move the patients through the system as quickly as possible.

Ms Phil Ní Sheaghdha: My colleague Ms Harkin-Kelly will give a brief overview of some of the issues that new entrants and student nurses particularly have identified as issues for them.

To address Deputy Donnelly's questions, I will start with the issue of pay. I believe the Deputy had left the room when I addressed the matter. Pay most certainly is priority number one for nurses, just in case the Deputy is in any doubt.

On the issue of fiscal space, I find it incredible that at the third economic dialogue, which was two weeks ago, health was not on the agenda. When I questioned the Minister for Finance in respect of the fiscal space, I asked him why he was prioritising a rainy day fund and why that fund was coming out of the fiscal space when we know — without being smart — the health service is absolutely flooded and leaking. We are still allocating €500 million to a rainy day fund, supported, as I understand it, by the Deputy's party, Fianna Fáil. I ask the Deputy not to be depressed because he actually has decision-making power in the position he is in to argue it is now time to invest in health to ensure we do not face what we are all telling him we will be facing this winter.

There are other budgetary decisions that can be made. The tax that was placed on sugary drinks is one example. The Minister's prediction for income from that is approximately €40 million. That is not ring-fenced for health, yet the health service is dealing with the problems of diabetes, obesity and other matters that directly affect the health and well-being of our nation because we are not tackling the alcohol dependency issues and bad dietary habits. If revenue from excise duties on cigarettes and alcohol and tax on sugary drinks amounts to nearly €100 million, why are we not investing it in health to ensure the health service is adequately funded? This is one point the members could certainly address.

With regard to the issue of tax relief for private health insurance, it has been said already that if there is cross-party support for Sláintecare, and if Sláintecare is the answer we get each time we raise the difficulties, which it is, and we support it and believe it is the right model, then we have to consider how we fund it from a timed perspective. We need to start showing citizens what occurs if we do it right. No citizen of this country has ever said in any patient survey that when he or she actually gains access to the service, it is bad. They say access is the problem. We are supplementing private health insurance in this country through tax reliefs to a quite considerable degree. The last figure I saw was €353 million. That is a lot of money. If our public health service had enough capacity, one could unwind that taxation supplement and there would be money to invest in the transition fund for Sláintecare. That has to be the focus.

The people who work in the service are doing their best. There are now looking to the Oireachtas. We wrote to this health committee to give them some support. It is not good enough to say one examined all the statistics and concluded nurses and doctors were well paid and that the service was adequately funded; that is not the case. Nurses are, in fact, the lowest paid in all the countries that are very actively recruiting from us. Brexit will exaggerate that in the United Kingdom. We know the United Kingdom is under severe pressure. It has approximately 20,000 nursing vacancies. They love our nurses and graduates. They love our nurses who are qualified for two or three years and they give them massive responsibility because they are able for it.

Deputy Stephen S. Donnelly: May I push back on that? Those two things are not mutually exclusive. According to all the data I have examined, Ireland is in the top five countries in the world where pay is concerned. There are approximately 210 countries recognised by the United Nations. If we are in the top five of approximately 210, it is fair to say that, by international comparisons, we do pay well. Ms Ní Sheaghdha is making a different point, which is the point made by Ms Clyne. Regardless of whether we pay well by international standards, there is a very small number of countries paying more. Unfortunately for us, they happen to be English-speaking countries and therefore our nurses and doctors can go to those countries and earn more money. If the pay rate in Ireland is among the top five in the world and there is a substantially higher starting salary than that of equivalently qualified people in the private sector, it is very hard to stack it up. It does not mean they do not have other options, which they clearly do. We know they do.

Ms Phil Ní Sheaghdha: I actually disagree with the Deputy's fundamental premise. Irish nurses are not well paid by comparison. We have international comparisons that are compiled not by us but by the International Council of Nurses, affiliated to the World Health Organization. They clearly indicate that, out of the nine main countries that are English-speaking with western medical styles, Ireland's pay is the lowest. I do not know what figures the Deputy is looking at but they are clearly not the figures that have been accepted by the World Health Organization and the International Council of Nurses. A nurse's starting salary is €28,700. We

do not even have to go outside Ireland. Even when we compare with other grades working in the public sector, such as teachers and gardaí, we note nurses' starting point is approximately €4,000 to €7,000 lower. That continues throughout their career.

I would like to address the issue of the benchmark with the private sector because I heard Deputy Stephen S. Donnelly say this before. When a nurse starts on a ward, on his or her first night on duty not long after qualifying, the responsibility he or she holds does not bear any comparison to what newly qualified accountants or engineers hold. They will not be building bridges and will certainly not be doing the final accounts. A nurse, however, will be looking after patients and will be in charge because that is how bad the system has become. A newly qualified nurse will rapidly be in charge of a ward once he or she is employed in the public health service. He or she will also be subjected to a fitness to practise inquiry if he or she makes any omission or mistake. Engineers' starting salary is not much lower than €28,700 and they quickly arrive at a salary that will get much higher during their career; therefore, they have aspirations. They will stick it for six months to a year because they know that it will get much better. Nurses are still on a low salary after 14 years. The point the Deputy is making does not make any material sense when one makes a comparison with the private sector because one cannot compare. In 2007, when the benchmarking body looked at this issue, it found that there was no relevant comparator with a nurse bearing the responsibility he or she carries in the private sector.

I have addressed the fiscal space and given some ideas that the committee has probably heard already. They are about decisions governments face. The fiscal space is a concept that is manipulated by decisions that must be made now. The reason we are here advocating on behalf of the health service is the decisions must favour the health service above all else, immediately and in the budget. To answer Deputy Louise O'Reilly's question about the consequences of the Public Service Pay Commission not dealing with the issue of pay, it will undoubtedly worsen a situation that is already a catastrophic crisis. This year we asked the HSE to tell us how many of the acute and closed beds it would be able to fund and open. It cannot tell us how many beds are closed and estimates that there are approximately 200 in the acute sector, which cannot be opened because of staffing issues or refurbishment. Health Information and Quality Authority regulations state capacity and design have to change. That will reduce the number of beds available. The HSE estimates that at the end of 2018 its target will be to have fewer than 100 beds opened. That is incredible. They are modest targets and the HSE is hampered by the fact that recruitment and retention of staff to facilitate the opening of these beds are not possible. Modular build is under consideration at some sites. It states there is capacity in South Tipperary General Hospital for a 30-bed modular build, but that argument has been on the go for nearly two years. There are difficulties in recruitment and retention of staff in that respect.

The one thing that has been proved to help the conversion of the agency spend is the framework for nurse staffing. When staffing levels are correct, the agency's spend will drop, as was shown and demonstrated in Beaumont Hospital, where it fell to below 0.1%. It works, but the problem is that it is not funded for implementation.

I was asked about the HSE's issues in people not wanting permanent posts. That is simply not the case. To pay a mortgage and meet childcare costs, our members tell us that they require permanent jobs, as well as flexibility in rostering and hours of work, which are not always available to them. In a female-dominated profession, that can have serious consequences, to the extent that some women are forced out of the workforce and to accept agency posts to have flexibility. It is true, however, that there are no conversion criteria. The HSE states that last

year it converted 712 agency nurses. Its bill is still just over €1.2 million a week in the statutory services alone, not including voluntary services. The HSE does not, for example, make provision for the replacement of nurses on maternity leave who are still counted in its census. There 37,200 nurses, of whom 2% on any given day are on maternity leave, but they are still funded and counted. Therefore, the roster has to be supplemented. We are not building or growing and are barely supplementing the roster. In many instances, the shift post goes unfilled.

Deputy Louise O'Reilly: They are short-staffed. A point was made about pay, on which there has been a focus. Will Ms Ní Sheaghdha comment briefly on the issue of the work-pay ratio? I represented nurses, whom I never considered to be well paid. I do not think that could be shown on a graph, but perhaps it could.

On comparators, we have heard about what people do in other countries. Ms Ní Sheaghdha made a comparison with engineers who do not build bridges on their first day, which is fair enough. With regard to a nurse, a consultant or a non-consultant hospital doctor at a similar level in another hospital, it is my contention that not only is the pay low but the workload is also high. When we compare, we are not only comparing pay. We also need to compare the type of work done and support provided and what we expect from the people who work in the health service for the money they receive. Will the delegates comment briefly on this?

Ms Phil Ní Sheaghdha: We have written to the leaders of all the political parties setting out the comparison from the point of view of hours of work and responsibility versus salary. Unfortunately, in all cases nurses come out the worst . We have high responsibility, are on low pay and work long hours. That is the daily grind. When compared with teaching grades, gardaí and other allied health professionals, we would be considered to be on a par, but we are on in the region of €7,000 less and, in some cases, €12,000.

Dr. Donal O'Hanlon: On the issue of work and pay for consultants, there are fewer consultants per head of population and they tend to see more patients, compared with their international peers. There tends to be intense pressure on finding resources for patients. We talk about patients on trolleys and trying to find beds for them. The struggle to find an appropriate setting for patient care takes up a larger portion of one's working day. The amount of clinical work one does is done in a shorter timeframe and more rapidly, while one tries to sort out administrative issues which I did not have had to go anywhere near in North America.

Mr. Martin Varley: I add that in a survey last week of 300 newly appointed consultants one third indicated that they had issues with the fact that their working week exceeded their contractual obligations significantly. In general, consultants are not paid overtime for working beyond their contracted hours. I do not even know of a situation where a consultant was paid overtime. Consultants can regularly work 10% or 20% of their hours overtime without pay, while in the United Kingdom they are paid automatically. Again, the workload factor washes through in several respects such as the size of clinics, ward rounds, hours worked and so on.

Dr. Laura Durcan: The number of patients seen per clinic is higher in Ireland than in any other country to which graduates might emigrate. The number of patients on inpatient lists is longer than in other countries. The working week is considered to be longer for most specialties, with some notable exceptions.

Dr. Peadar Gilligan: To give a specific example, a department of our size in the United States would have 28 consultants, while we have four. That gives an idea of the workload involved.

Deputy Louise O'Reilly: That puts the matter into perspective. I thank Dr. Gilligan.

Ms Susan Clyne: The NCHDs have longer hours. They have much more responsibility and pressure. The NCHDs are entitled to get overtime but they are not paid for it. The system actively discriminates against them and stops them from claiming even their contractual entitlements.

Ms Martina Harkin-Kelly: I apologise for my hoarseness. Even though we work in the health service, we are subject to illness and vagaries within the health service as well. I welcome the debate. I am somewhat perturbed by what appears to be the messengers being shot this morning in respect of the issues we are bringing to the committee's attention. As we sit here, 37 patients are awaiting beds in University Hospital Limerick. There were 63 waiting for beds yesterday. There are 28 awaiting beds in University Hospital Galway today. In total, 284 citizens of this country are languishing on trolleys and in inappropriate spaces in our emergency departments today.

While pay is a huge problem, another difficulty is the political mindset which views health as a leakage rather than as a priority. Spending and making the correct investments will offset much of what I refer to as the revolving-door patients coming through our emergency departments.

The problems relating to pay, recruitment and retention apply across the board. I am dismayed that as we are celebrating the centenary of women getting the vote, 92% of nursing profession are female and yet we seem to have the denial of pay for work that is vital work within this economy. We are all professionals as my medical colleagues have said. While I am not particularly looking at Deputy Donnelly, in the context of the work we do, I do not think, as Ms Clyne said, he can compare architects with nurses or medics. The decisions we make are critical to the life of the individual. There will always be stops and checks in place when a bridge is being built and before traffic is allowed to cross it. That does not happen in the health service environment. We make acute and critical decisions, and we are not always supported by our employer.

Everyone has pointed out that medical professionals are emigrating. The weather is lovely at present and we are enjoying it. However, the pay differentials are obvious. There is a moral dilemma attached to what we are not currently able to do. Nurses and medics go elsewhere because they are able to action the care they want to action in other jurisdictions. They are given the capacity and the resources. They are not made feel potentially bad about it.

Senator Colm Burke spoke about a survey he carried out. We have conducted two surveys of our new graduates, one in 2017 and one in 2018. Astonishingly in 2017, some 79% of them said they would emigrate. The survey in April of this year indicated that 71% of them would emigrate. The elephant in the room is, of course, the need to increase pay and, above all, staffing levels. Some 76% of them said staffing levels are not adequate to support their learning in the clinical environment. As Ms Ní Sheaghdha pointed out, newly-qualified nurses make critical decisions with very little support. There is not the support from senior qualified staff because we also have difficulty retaining them in the system.

We have heard much of the political, economic and socioeconomic factors and we have heard much about the demographics. However, the demographics within nursing are that 65% of us are over the age of 40. We have a conundrum with regard to those people even being in the system within the next 15 years. Some 57% of the graduates we surveyed had been approached

by overseas agencies and only 18% were offered permanent posts by the HSE. There is a dilemma. As Ms Ní Sheaghdha pointed out, pay differentials are huge. It is a sad indictment of the system that a staff nurse has to work 15 years to reach a salary of €45,000.

Deputy Louise O'Reilly: Did Ms Harkin-Kelly indicate that only 18% of graduates had been offered permanent posts?

Ms Martina Harkin-Kelly: Some 18% were offered permanent posts at that time.

Chairman: I will call Senator Colm Burke in a moment.

I wish to return to the global issues. The Committee on the Future of Healthcare sat for 11 months and produced the Sláintecare report. While the Sláintecare report is viewed differently by different organisations, it was a cross-party report looking at the future of healthcare and offering a ten-year vision for the healthcare system. The Government has yet to respond to many of the recommendations in the Sláintecare report, 400 days after it was published. Every month it claims its response is imminent. I understand that the costings for Sláintecare have been challenged and that it has gone to the Department of Public Expenditure and Reform for review. Many of the Sláintecare report recommendations would not prove very costly because it recommends a change in the model of care, in the system and within the HSE.

I would like Mr. Varley to comment on one of the recommendations in particular. I refer to that relating to the separation of private care within the public hospital system. The argument is that if that private money is taken out of the system, the system will collapse. We are saying that we expect the public to take out private health insurance so that it can subsidise the public health system, which is not sustainable.

As Deputy Donnelly stated, it is not so much a question of how much we are spending on the health services, but how we are spending that money and where it is going. Ireland is one of the largest spenders on healthcare within the OECD. However, I am of the view that we are also one of the largest spenders on bureaucracy in our health service. Representatives from the HSE appeared before the committee last week. The HSE has developed a unit for scheduled care and unscheduled care and how it manages appointment waiting lists. How can we reconcile the amount of money we are spending on managing the waiting lists when really we should be putting that money into front-line services? The health service is a closed system. If investment is reduced in one part of the system, the patients do not go away; they just go to the next part of the system. That certainly is the case in primary care where if that is not properly resourced, people end up in casualty or on hospital waiting lists. I would like to hear a comment on that.

We often speak in abstract terms about how these things happen. I was recently contacted by a GP who had a patient who had pyelonephritis and a stone in her kidney. He decided to send that patient to the medical assessment unit where she could have her X-ray and ultrasound, and avoid going to casualty. However, the medical assessment unit said that was a surgical problem. The surgical assessment unit said it does not deal with renal problems and directed the patient to casualty. Here was a GP trying to avoid sending to casualty somebody who needs a diagnostic test. However, the patient ended up in accident and emergency and was obliged to start from the bottom of the assessment system again.

This happens every day. GPs are being sidelined and disenfranchised. They want to participate in the health system and look after patients and deal with chronic care. However, they are not given the resources or access to diagnostics. That is a practical example of how the system

is not working.

Sláintecare provided a ten-year vision, but unfortunately we have a crisis intervention vision at the moment. We are not looking at the ten-year vision for the health service. As one of the witnesses mentioned, we are not capable of providing prevention measures in order to try to keep people out of hospital and avoid diabetes. We need to try to reorientate the taxes we take we collect from health taxes into the system. The Sláintecare report also recommended that those taxes be ring-fenced.

Earlier, Deputy Murphy O'Mahony asked if the Department of Health is negotiating on a new GP contract in good faith. Are negotiations on a new GP contract taking place or are we just adding bits and pieces to the old contract? The contract negotiations have been going on for two years now but nothing has come from them. GPs feel they have been sidelined. They are anxious to participate in the health service and they are champing at the bit to get involved in looking after patients properly within the community. However, they are not being valued, recognised or resourced. I ask Mr. Varley to respond to my first question.

Mr. Martin Varley: We made a substantial submission on this matter to the independent review group. The key question is what would happen if we were to separate the private and public systems. The report appears to me to be based on the premise that this would create capacity in the public hospitals because a proportion of the population with private health insurance use public hospitals. Our analysis would suggest that they use the public hospitals out of necessity because the equivalent care is not available in the private settings. There are specialist areas, for example, cancer care, ICU care, maternity care, paediatrics, organ transplantation, stroke care, trauma, neurology and complex surgery, which, by and large, only happen in the public hospitals. This could be fragmented and replicated across the private hospitals but the country is not large enough to have two groups of specialists. We have enough difficulty trying to recruit and fill public contract posts such that trying to replicate the system in two settings would be highly questionable. The population of Ireland is not much bigger than that of the greater Manchester-Liverpool hub and duplication does not make sense. Also, if we take €650 million to €700 million per annum out of the public hospital budget are we guaranteed that it would be replaced? We do not believe there would be much of a reduction in the number of patients presenting. The same patients will present albeit one would forego the private health insurance income that the public hospital would have received. This whole basis of the report is open to question. We do not believe it would lead to a stronger medical service in the country if we fragment it. It would be better to develop centres of excellence, as we have done with the cancer centres. Fragmentation is not the best approach and 45% of people continue to have health insurance and to pay for services when they use public hospitals.

Chairman: If consultants' pay was equalised and the pay scale increased to €211,000, surely that would be sufficient to attract doctors to come and work exclusively in the public health system.

Mr. Martin Varley: That is for type A consultants. In terms of current employment in our public hospitals, 6% of hospital consultants are type A contract holders. The balance are type B or B*. Obviously, this would continue. In March 2011, the HSE took the view that all future hospital consultant posts would, save in exceptional circumstances, be type A. The outcome of this was that recruitment stalled. The HSE then reverted to a position whereby it would be, by and large, type B contracts in public hospitals.

Chairman: If the pay scale was brought up to the level mentioned, would that attract con-

sultants to work in the public system only?

Mr. Martin Varley: Yes, but for certain specialties. It would be in the minority of cases because the majority of people are seeking type B contracts. Let us not forget that we are competing with posts being offered to specialists in North America and Australasia. In that context, Dr. Durcan mentioned that she was offered twice the salary she was offered here. The new entrants discrimination has become more severe in recent times. As stated, people are being offered twice the salary abroad.

Chairman: Is Mr. Varley saying that doctors will not work in the Irish health system unless they are allowed to have private practice?

Mr. Martin Varley: All of the indicators are that in most specialties doctors come back on the basis of a mix of salary and private practice income coming from private patients in public hospitals. Our system has probably been designed to some effect with a view to maintaining our competitiveness. This is part and parcel of the contract and of our being competitive.

Chairman: The point I am making is that what we are doing now is not working. Sláintecare proposes an alternative model and, in some instances, a radical one. There is universality within Sláintecare, such that people will be treated on the basis of need rather than ability to pay. We have a system that allows people to be treated on their ability to pay rather than based on need. The aim of Sláintecare is to change this system.

Mr. Martin Varley: I would suggest that the root cause of that problem is the lack of capacity. All patients presenting in public hospitals are listed for care based on clinical need. There are bottlenecks in diagnostics, first and foremost, in admissions - owing to a lack of beds - and in terms of access to theatre. The comparison to which the Chairman refers is a comparison of the private hospital system with the public hospital system. It is not a differential of treatment within the public hospital. I have yet to come across situations whereby there is differential treatment. The capacity issues are causing the problems. As an insured person, if I need to access diagnostics in the morning and I cannot access it on time in a public hospital, I will go to a private hospital. If I have a serious ailment and I need to be treated in a public hospital and the public hospital is the only place which provides that care, I will then present at a public hospital and I will be treated on the basis of clinical need. It is unfair to suggest that the public hospitals are in one way or the other prioritising. It is because of capacity restrictions that people cannot be diagnosed on time and they cannot get in for treatment on time.

Chairman: I thank Mr. Varley.

Ms Phil Ní Sheaghdha: On the question of private beds in public hospitals, we also made a submission to the independent review. The costing takes into account the private health insurance deficit that would follow rather than the current cost of having private patients in public hospitals. The issue that underpins the premise of the Sláintecare report is equity, which we fully support. There is no doubt that there is a fast track in the context of having private health insurance. The unwinding of the tax relief for private health insurance will only happen when the services are provided by the State in public hospitals and there is confidence among citizens that they do not need private health insurance. This confidence has to be brought about very quickly. This undoubtedly is an issue of capacity but it is also an issue of adequate staffing to open more beds, including the people we represent.

Dr. Peadar Gilligan: That no patient should be impoverished because of health related is-

sues and that there should be ready access to care is correct. Our anxiety is around the removal of €600 million from the health service. The point was made that private insurance subsidising public hospitals is not sustainable. Without the income they receive from the insurance companies for the care they provide to patients privately, public hospitals would be very challenged in continuing to provide care. The budgetary allocations to hospitals changes year on year. There were many years when the certainty was that the budget would be less than it was the previous year, despite the fact that there had been an overspend in the preceding year. Hospitals are reliant on the money they get from patients treated privately within the hospital system. We would need to be very reassured that this is going to be fully replaced and that hospitals will have a reliable and appropriate budgetary allocation for the work they undertake.

The Chairman also asked if the ability to augment income is an incentive to people returning to consultant posts in Ireland. It is most definitely an incentive. Would addressing the issue of the discrimination visited upon consultants since 2012 help us to recruit? It would definitely help. Until we address it, we will not be able to recruit the numbers that we need. On the case study which was brought to our attention regarding the patient with the clinical conundrum of pyelonephritis or renal stones, that is an issue that emergency departments around the country deal with on a daily basis and can deal with very effectively between history examination investigations and appropriate imaging. We would generally refer the patient on to a urology colleague or a surgeon with a special interest in that area. The reason alternate routes are being sought for managing that patient is that we as a nation have treated for too long our emergency departments as holding bays for patients who need to be in hospital wards. That is the reason we are all here today. We are here to try to address the overcrowding issue. I can assure the committee that emergency physicians can help make that diagnosis readily and help treat that patient readily.

As to whether GP colleagues are being frustrated around the country by an apparent lack of engagement, I would say that our GP colleagues provide a significant level of care. There are 20 million patient interactions by our GP colleagues in Ireland annually. They provide a significant level of service. They deal with the vast majority of patients within their own surgeries or on home visits. It is a small percentage of patients that they send on to the hospital system where they need our care and where they need the capacity within the system. Of course, they work extremely well with community intervention teams and with public health nurses, and, indeed, with their own practice nurses as well, to provide a high level of care.

I will hand over to Ms Clyne to address the question of whether they are frustrated by the lack of progress on contract talks but I think "yes" is the answer.

Ms Susan Clyne: The short answer is "yes". To clarify, GPs are, in fact, represented here today through the IMO which has been the negotiating partner on the GMS contract since its inception.

There are issues with the negotiations that are well known. They have been going on for a very long time. Since the time the contract negotiations started, emphasis shifted with the arrival of Sláintecare, although it is unclear to GPs and the public in general as to whether Sláintecare will be implemented despite it having cross-party support.

The IMO was in contract negotiations for all of 2017 and progressed very far around the areas of chronic disease and capacity, which were issues highlighted, both by Professor O'Dowd's report and the Sláintecare, as priorities for general practice. However, it was clear from the budgetary allocation last year of €25 million that that would not be possible. In truth, it is not

a question of good faith or otherwise. What is holding up negotiations is the lack of resources.

However, we must be clear, from the IMO's point of view and from all GP members' point of view, that as long as FEMPI is not restored there is no hope of getting new services from general practice because the existing services are not financially viable. There must be a road-map to restore FEMPI. These are all the issues that drive people to retiring early, practices not getting any applicants and young trainees not working here. The gap of 38% is considerable. Every other public servant and politician has had his or her FEMPI reversed. General practice is out on its own and has had nothing reversed for it. That must happen. It is not viable in any way to say that general practice can take on all this new work while the foundation and the underlying model is not funded properly.

The IMO's position is that there must be a roll-back of FEMPI and then there must be additional funding for any new services that are to be brought in. It is not an either-or issue. It is not that new services can be brought in on the back of FEMPI. That would merely crucify the system. General practitioners are frustrated. Patients of GPs are frustrated. Patients of GPs are now becoming a rare breed because in many counties around the country patients cannot find and enlist with a GP and are resorting to have to go to the out-of-hours service where there is no continuity of care. According to research in the UK, continuity of care saves lives. It is that simple.

We have been before this committee previously on the GP issues and we are happy to return on more GP issues. This meeting today is specifically about general practice. We brought general practice into our presentation insofar as over the long term with proper investment we can reduce hospital admissions and general practice can assist in reducing presentations on the waiting lists.

Chairman: Before Deputy Durkan comes in, because he has been in on a number of occasions-----

Deputy Bernard J. Durkan: I know have. I am still anxious to come in.

Chairman: I know that. We will not leave the Deputy out. Following a brief comment from Senator Colm Burke, we will go to Deputy Alan Kelly.

Deputy Alan Kelly: I thought the Chairman was going to ask me to be brief.

Chairman: I am going to ask the Deputy to be brief.

Senator Colm Burke: My apologies for not being here when they gave the replies. Unfortunately, I was in the Seanad dealing with a health issue.

On the 11,000 additional staff in the HSE, if there are to be improved levels of employment where we are already talking about over 450 consultants who are not in place and nurses not being in place, within the HSE we still do not appear to be prioritising the front-line employment. For example, when I looked at the figures for the additional 11,000 staff employed in the HSE over a three-year time period, there was a 17% increase in administration staff and only a 3.5% increase in public health nurses. That does not appear to have been a logical decision to take. I wonder what influence all of the players present have in trying to get the HSE to take the logical decisions on this matter because what I do not want is a situation where such an increase in staff continues.

The second issue I want to touch on is security in accident and emergency departments. I am aware the IMO referred to it. What action can be taken immediately to assist staff in dealing with that issue? All of the hospitals have security staff. Is it a case that there is not enough security staff employed or that sometimes during the week we would be better off having gardaí permanently posted in accident and emergency departments to ensure that there is security and safety for staff? I wonder how we deal with that. The number of assaults the IMO referred to is extremely serious and it cannot be ignored. People are trying to provide care for a significant number of people and their own safety is at risk. I am wondering what can be done on that. That is something that can be done immediately. I wonder whether we can deal with that even today.

Chairman: I thank Senator Colm Burke and ask the witnesses to store those questions. Deputy Kelly will be brief.

Deputy Alan Kelly: I am never brief.

Chairman: The Deputy has five minutes.

Deputy Alan Kelly: I am sorry for being late. I am trying to multitask today. I am also a member of the Committee of Public Accounts, which launched a report earlier.

First, I am sorry Deputy Donnelly has left because I was switching documents after the previous meeting and I saw his contribution. On nurses' pay and conditions, I am not sure what planet the Deputy is on. As far as I am concerned, he was not comparing apples with apples or oranges with oranges.

There is a crisis in nursing in the country. There is a crisis in the area of workforce planning in relation to doctors, GP contracts going nowhere and consultants. It is the biggest issue, along with capital expenditure, in the country.

When it comes to nurses' pay and the conditions under which nurses must work, the process by which increments come in, the training required and the scaling up of their work at a fairly quick pace, Deputy Donnelly was not comparing any rate of pay that I could recognise as being a correlation. That issue will have to be dealt with.

I have a real issue. Members of my own family work as nurses in hospitals. We need a health and safety trolley watch. The public needs to know what is going on out there. I hear it every week. The public does not actually know. It will come to a crescendo soon. We need to be monitoring this and producing statistics on what is happening to staff, including doctors, particularly nurses, and, dare I say it, porters as well, in the HSE. I would encourage some way in which that could be done through the unions.

On bed capacity, obviously there is the famous capital plan that is coming out and the modular builds. Through everyone's evidence here today, do they believe that there is a pace afoot in order to deal with the bed capacity in the capital build and the modular build that is being brought about? I represent Tipperary. I have got the two worst accident and emergency departments in the country either side of me - Limerick, which is closer to me even though I am in Tipperary and South Tipperary General Hospital. Both are looking for modular builds and need them fairly quickly. If the witnesses have evidence on that, it would be helpful.

I have been talking about the issue of e-health for three years. My background is in technology. I have not seen much progress. It is a significant part of the Sláintecare report. I

fundamentally believe work practices will change if we can advance in certain areas here. My evidence from talking to people, and I talk to many people in healthcare, is that this is going higgledy-piggledy and where there is progress it is not replicated. I would like comments on that. The real question I want to home in on is the issue of pathway of care. This is my last question and I am being brief by my standards. I come from the mid-west. We had a number of reports down through the years, including the report of the national task force on medical staffing, the Hanly report, on change in Ennis hospital, Nenagh hospital and St. John's Hospital, as well as the situation in University Hospital Limerick.

The manifestation of that is what we have now. I am not saying all the parts of the Hanly report were wrong - some of it was right. The issue is the process by which we got there flooded University Hospital Limerick. There is an issue where GPs, in the circumstances, are referring a large amount into Limerick. I refer to the pathway by which people can be serviced in the minor injury clinics in the other three hospitals. St. John's Hospital is closed at the moment and it is ridiculous that more cannot be done in Nenagh and Ennis hospitals. As the Chairman is well aware, both have excellent facilities, as does St. John's. Nenagh has the best operating theatres in Ireland but patients are not being transferred into these hospitals for after care and minor surgery for many different reasons.

There is a lack of a discharge protocol and in some cases it is something basic like not being able to get intermittent vehicles to transfer patients to after care. I have experienced this with my own family. On pathways for referrals into hospitals, we had an accident and emergency unit which ended up three and a half times the size of the original but the volume of patients increased by 24% because it was thought more could be accommodated. We have to improve the pathways in and out of the network of hospitals. An example of something done well recently is the centralisation of cataract surgery in Nenagh because it has the theatres and it is going to have extra beds as more blocks are being built etc. It is in the centre of Ireland, surgeons like operating there and it has very good theatres. The lists are off the Richter scale.

That is a good example but the pathways for electives and how patients are cared for post surgery and after being in the main hospital have to be improved to ensure there are more beds. The discharge policy and the policy under which patients are being serviced in the network are not working. It can be helped easily without much funding or change. Those are my comments because everything else has been covered.

Chairman: I thank Deputy Alan Kelly. I am going to allow Deputy O'Reilly and Deputy Durkan in for one question and then we will try to clear all of those questions.

Deputy Louise O'Reilly: It is amusing to hear people coming in here as if this crisis has just happened overnight. We know it is the result of successive Government policies. I have two brief questions. One is on the national treatment purchase fund, NTPF. Ms Clyne briefly touched on it but I would like to get the views of the other witnesses. I have heard it described as a sticking plaster and a short-term solution. It might look good on paper but it is not going to impact long term. I have my own view and it has been well ventilated but I am interested to hear the views of the witnesses.

My other question is on the mental health and well-being of staff. The conditions as described are horrific. The representative organisations will do the best work they can to look after the staff but who is looking after them? Are any programmes in place? Who minds the health and well-being of the people who are minding the health and well-being of the patients?

Deputy Bernard J. Durkan: We are all pursuing the same objective. We are trying to get a system that works seamlessly, flawlessly and smoothly from the patient's point of view. What we deliver has to be from the patient's point of view. If we do not deliver that, we are not successful. Incidentally - it is not fundamental to this argument - politicians have not been recompensed following the cuts nor should they be. It could be said in certain quarters that they were overpaid at certain levels. I do not want to go down that road, it is not a good argument. I will put it that way. New politicians have been paid the same as always but older politicians with longer years of service, like civil servants, GPs and various other people, have had their increments abolished. I am not making an argument about that.

Deputy Louise O'Reilly: The Deputy will get no sympathy there.

Deputy Bernard J. Durkan: No, if that were applied to other parts of the public or private sector there would be much talk about it and nobody would complain.

Deputy Alan Kelly: Stop it.

Deputy Bernard J. Durkan: I will come to that in a minute.

Dr. Donal O'Hanlon: I am sure I am in the firing line.

Deputy Bernard J. Durkan: I have asked about the role of the primary care centres many times. I still do not know and no one seems to be able to tell me why the intervention of the primary centres has not shown a visible improvement in the delivery of services to the patient at local level. Given the extensive nature of the facilities, I thought the intervention would have been of benefit to the patient who did not require major surgery for example and who required access to a consultant or a GP, etc. It is local, it is available, so why does it not happen? Incidentally, in one particular case, I discovered the opening hours of the primary care centre were two hours earlier than was the case with the GP service previously. I would like that question answered.

I feel we have a duty not to give a false impression to the general public as to what can be done. The rainy day fund comes up. It should be known and recognised that the rainy day fund is there for a purpose. Revenue accruing to the Exchequer is removed from one particular area or a number of areas. There is a debate about where it should go. Should it go into the rainy day fund to prepare for pitfalls that are visible on the horizon right now, like Brexit and other things, or should it go into current expenditure? It is as simple as this. We know what happened before when current expenditure went out of hand as a percentage of our economic performance.

I want to hear what the answers are. I would, however, also like everybody to recognise that there are consequences in the event of current expenditure exceeding the recommended rate of gross domestic product, GDP, gross national product, GNP, or any other measurement. If we have another recession like the one we have barely come out of now, that will be permanent because we will not find so many people ready to bail us out the next time.

Ms Phil Ní Sheaghdha: I will try to deal with the questions as they were raised.

Chairman: I ask Ms Ní Sheaghdha to be as brief as possible.

Ms Phil Ní Sheaghdha: That is fine. On security issues, I will answer Senator Colm Burke and Deputy O'Reilly's questions at the same time. All of the research tells us that when staffing levels are low then assaults go up. We have to have the proper staffing levels to avoid the

frustrations and the long wait times etc. We had a dispute in 2016 and part of the settlement was that there would be a security analysis of accident and emergency departments. We found that while the hospital might have security personnel, they may not necessarily be stationary in the accident and emergency department for the 24 hour cycle and that is still the case. Many accident and emergency departments do have security personnel, many do not but the hospital might have for some of the 24 hour cycle.

We have already alluded to the drugs and alcohol issue, the presentations and the fact that is putting our members, and our colleagues working with us, in danger. There is no doubt about that. An education piece needs to follow this. Is it the responsibility of the trade unions? Everybody knows health and safety legislation requires the employer to ensure a safe place of work. We have raised this as an issue and we have gone into dispute on it. It remains an issue that may raise its head as dispute issues arise around the country in the next number of weeks because it is simply not acceptable.

I will address the workforce plan. The idea that we know all this and yet in the month of July we are still waiting for a plan to tell us how may nurses and midwives will be funded seems to contradict the requirements and obligations of employers under the safety, health and welfare at work legislation. It is irresponsible, frankly, that we do not know.

Deputy Kelly referred to the modular build. We have been involved in discussions in respect of South Tipperary General Hospital. The issue there is space. Over the past two years the authorities have been looking at the car park. There has been an issue in respect of the admission criteria. What type of patient can attend that modular build when we do not have access to the main hospital? Can we put acutely ill people into a modular build like that? We argue that one cannot. There is an issue in respect of the modular builds in Cavan. I was there two weeks ago. One nurse was on her own at night looking after 17 patients away from the emergency department and the main thoroughfare. These modular builds have to be staffed properly, and they have to be proximate and they have to be secure. For the sake of patients, staff have to be able to run with a crash trolley if somebody experiences an adverse event. Staffing is going to cause the delay.

The Deputy is correct in regard to Limerick that the reconfiguration in both the west and the north east put the cart before the horse. The capacity was removed and it was not increased by the measure that was required. That is why there were problems in Our Lady of Lourdes Hospital Drogheda and that is why there were problems transferring into Beaumont Hospital in those years. In the mid-west the problems continue because capacity has not increased. Efficiencies can be introduced, certainly in respect of the voluntary hospital, St. John's Hospital, Nenagh Hospital and Ennis Hospital. There is no doubt about that.

I refer to information technology. It makes no sense that we still spend hours writing patient histories and looking for files. The Sláintecare report calls for transitional funding earmarked for building IT infrastructure. That makes sense and has to be addressed.

In response to Deputy Durkan on the rainy day fund, it is fairly straightforward. We are not looking for current expenditure. What we are saying is that we have choices**.** The current crisis in health will not be fixed by saying that there could be another catastrophic crisis in eight months. The transitional fund outlined in the Sláintecare report is clearly tied to a time period and it is not ongoing. We need to make sure that we transition to the right model. That will cost money upfront, but it is will not be an ongoing cost. In fact, it will reap significant savings on an ongoing basis.

Primary care services are underfunded and understaffed. We all have a different impression of what primary care means. Clinicians working together out of the same building is a good idea. It means that referrals can happen much more quickly. However, we are on the record as saying that we believe the staff have to be employed by the same employer, which is a problem. We also believe that there is major capacity in the community for the advancement of nursing services and public health nurses. The Sláintecare, capacity review and ESRI reports stated that there is an underinvestment in public health and in community nursing services. That needs to be addressed, because many roles can be nurse-led in the community. They provide good value for money and will develop, and they will prevent people from having to be admitted to hospital.

Dr. Peadar Gilligan: I wish to respond to Senator Burke on the issue of additional staff within the system and his concern that we are not getting the right staff in the right places. That comes back to the recruitment and the retention challenges and whether people feel valued within the system. We have highlighted the fact that the disparity in pay at consultant level is one of the main blocks in this respect. The failure to honour the contracts of NCHDs is certainly a block to recruitment at that level, and the failure to reverse the FEMPI provisions and engage properly on the GP contract is the challenge to recruitment and retention of general practitioners in our health system.

I refer to the issue of security in the emergency setting and in the hospital setting in general. If we want our emergency departments to be safe, we should not overcrowd them. We should not have them running at 200% and 300% of their available clinical space, occupied by people who should be on wards. People coming to emergency departments are distressed by the conditions they are coming with. They are often anxious and upset. The last thing they want to experience is an even more stressful environment. As a nation, we have to get that right. If we can get that right, we will make the patients' journey safer and we will make it safer for the staff working in hospitals, because we will make the environment in which patients undergo their initial assessment, and in the majority of cases all of their management, less stressful.

I acknowledge that the intent of what Deputy Kelly said was not to cause hurt, but I note that he described the two emergency departments in his constituency as the worst. I think what he meant to say was that they are the most challenged with regard to overcrowding.

Deputy Alan Kelly: I am glad Dr. Gilligan clarified that.

Dr. Peadar Gilligan: The wording is incredibly important.

Deputy Alan Kelly: I meant to describe the challenges and volumes that they face and the overcrowding that they end up dealing with.

Dr. Peadar Gilligan: Absolutely.

Deputy Alan Kelly: The people who work there are fabulous.

Dr. Peadar Gilligan: Exactly. The reason I am pointing this out is that the last thing people working in challenging environments want to be told is that they are working in the worst place in the country.

Deputy Alan Kelly: To be fair, Dr. Gilligan knows that is not what I meant.

Dr. Peadar Gilligan: The reason I am highlighting it is the importance of the words we use

and the way we speak about issues. Nurses and doctors working in emergency departments put their lives at risk. I know that by virtue of the fact that three members of my staff-----

Deputy Alan Kelly: I know.

Dr. Peadar Gilligan: -----were injured by a patient last weekend. That is happening around the country.

Deputy Alan Kelly: Members of my own family were injured.

Dr. Peadar Gilligan: Absolutely. It is important that we make the people working in that challenging environment feel valued, and the way we speak about them is incredibly important. The way we remunerate them is also incredibly important, as we have also referenced today.

Ehealth is an area of particular interest to me. We have made a lot of progress with regard to telemedicine in stroke care and acute coronary care. There is scope for further development. However, many hospitals have IT systems that are falling over or do not have IT systems at all, because there has not been capital investment in the hardware, software or staffing required. That is an area for investment, and could help us into the future.

Deputy O'Reilly referred to the NTPF. The fund advantaged certain patients who have been appropriate to receive care there. Our problem with it is that we are taking money from an under-resourced system to pay the private sector to do what should be deliverable within the public sector. That is what we have to get right. It is a sticking plaster. It will not be sustainable in the future, and not enough people will benefit if we continue with that model of care. We need to invest adequately in the system in general.

I refer to the issue of the mental health services staff and who looks after them. The staff members are looking after each other. The nursing and medical staff, the health care assistants, porters and security staff all talk to each other. We try to support each other through the situation. Many hospitals also provide counselling through their psychology services if they are in a position to do so. However, if we want to care for our staff, we have to get the overcrowding issue right. By doing that, we will enable them and facilitate them in caring for their patients. That is what we are there for and that is what we want to deliver on.

I would love a seamless, flawless delivery of care, but I would be happy with a safe delivery of care. To achieve safe delivery of care, I need to have a bed available to the patients for whom I am providing care and who needs hospitalisation. I need to have a trolley available for the patient I need to assess within the emergency department, and, to have that, I need capacity in the system which the political system needs to deliver for us. That is why we are here.

Deputy Bernard J. Durkan: What about decommissioned beds?

Dr. Peadar Gilligan: Let us get those back in circulation. However, again, resourcing is required in that regard.

When primary care teams function, they function extremely well. The concept of the GP, practice nurse, physiotherapist, occupational therapist, psychologist and podiatrist all working together for the patient is terrific, but they have not been resourced to the extent that they need to be throughout the country That needs to happen because we do not have the sort of numbers we need.

Deputy Durkan and I debated the *per capita* expenditure previously and the fact that we are

spending a lot of money on health care. We see 1.4 million patients each year in our emergency departments. There are between 18 and 20 million patient attendances at GPs, hundreds of thousands of procedures are performed around the country and there are hundreds of thousands of outpatient visits each year. That is a costly. My concern, which I have expressed previously, is that when we talk about *per capita* expenditure, we are talking in terms of out of pocket expenditure, insurance premium expenditure and the Government expenditure component. The Government expenditure component is not adequate and that is the only strategic spend we have within the health system. We need to get that right. We need to resource the system such that patients can have confidence that they will receive safe care.

Dr. Donal O'Hanlon: Our structures in the health service need to be better aligned on a local level. The division between the community care organisations and the acute hospital sector, and the acute mental health sector, the fact that they report to different management structures, needs to be reconsidered. It does not make sense to develop a system this way. The term used these days is "geoalignment". We have also been concerned at the lack of a governance structure. We have an executive in the HSE, but very few governance structures nationally, or even in local community health organisations or hospital groups. The integration of that governance function for the acute hospital service, community services and mental health services in a geographical area would be a great advance. That would allow us consider some things that would be beneficial. In any of those groups we need a coherent ehealth system where we can pool information on people, and not duplicate tests or go over the same information again and again at each patient contact. Those systems need to be able to talk to each other between those different community organisations. That also touches on the issue of staff burn out and the mental health of staff. That cannot be minded by a large organisation of more than 100,000 employees. It has to be a part of the management structure locally to try to sustain people in their work.

The NTPF is a short-term solution but it has some drawbacks in continuity of care and we would be much better off funding capacity that would stay with us over the years. The pathways of care could be greatly helped by having a coherent integrated health service management structure on a large regional basis.

Mr. Martin Varley: To comment on what Deputies Kelly and O'Reilly said about capacity, I agree that the NTPF is a short-term solution to a crisis situation. The issue is the lack of capacity and we were quite heartened by the fact that the NDP has provided funding for an additional 2,600 beds but we are concerned that we are not seeing the annual plans to commission those beds. With a lead time of seven years to get a bed in place from beginning to end in the health service, I am concerned that we will not see the 2,600 within a reasonable timeframe. My one big ask of the committee is to request the HSE and the Minister to put on paper the timeframe for the 2,600 beds. They are funded. We just need them put in place. That would be a big start. If we could get certainty on that number, people would be encouraged that we might be able to put a dent in the number of patients on trolleys and on waiting lists. We hope progress can be made on that and we would welcome progress.

Deputy Kate O'Connell: Mr. Gilligan referred to governance structures at local level. Are we going back to the health boards of the past? Deputy Durkan would be delighted with that. Does it need to be more localised? Is that the structure Mr. Gilligan is talking about, or is it like the proposed board of the HSE or a sub-board?

Dr. Donal O'Hanlon: There is a division between community organisations and hospital groups, different management structures and different allocation of resources but many of the problems overlap. At regional level, I do not know what population would be best. Any

hospital group and the community healthcare organisation should have the same geographical boundaries and the same type of management structures. As well as having an executive role such as the HSE provides, there needs to be a board and governance structures.

Deputy Kate O'Connell: That is a key part of the Sláintecare report. With regard to the components of the electronic systems speaking to each other I have a concern about patient confidentiality. My background is in a community pharmacy, and I am concerned especially about addiction services or people with HIV, or other health issues that are so personal that they do not want to deal with the doctor or community pharmacist in their own areas. I am concerned about having a huge system that everybody has access to because there have been examples of people accessing other people's social welfare details out of nosiness. How do we protect the patient? Should community pharmacists and the doctor in the hospital be able to see everything? There might just be the nosey neighbour wanting to find out about someone. It is important that personal data are not available. Firewalls must be put in place to prevent a breach. Can Dr. O'Hanlon give us any advice on that?

Dr. Donal O'Hanlon: I am afraid my advice is a bit dated as I have not been working in a system with a good ehealth infrastructure. There are mechanisms for putting sensitive information into different locked files with limited access. It would be imperative that people face sanctions if people were looking up information on others.

Deputy Kate O'Connell: It would have to be prison for such breaches.

Dr. Laura Durcan: I worked in the US in two different large healthcare systems. There was an integrated healthcare system and we could access somebody's records from the different institutions where they had sought care in the state of Washington. The psychiatry records were generally closed so I could not access those. Similarly, there were different levels of access. For example, a healthcare assistant would get to vital signs or medication, which would not be considered sensitive. There was a different level according to the person's log-in on the computer. Everyone was paranoid and a person had to swipe their card every time they accessed the system. A big notice came up asking was the user providing care for this person before accessing that record. That worked well.

Deputy Kate O'Connell: I have one final question for Mr. Gilligan. With regard to the step-down facilities in place, in particular Mount Carmel Community Hospital, which is being operated by a private company, I hear anecdotal evidence that patients are resisting going to particular step-down units after the consultant has signed them off for discharge. Is there a blockage in the system where patients are ready to go and there is a place for them but they will not go?

Dr. Peadar Gilligan: The majority of patients are aware of the great pressure to move patients through hospitals. One of the issues that arises for certain families is patients being moved to a location that is distant from them affecting the ability of people to visit. Where possible the hospitals try to address that locally with the patient. That happens and causes frustration for the patients, their relatives and the hospitals in a minority of cases.

Deputy Kate O'Connell: It is not a huge problem.

Chairman: To sum up, this morning and last week we have identified the problems and the solutions but unfortunately we fall down, as happens with many other reports, on implementation. We have huge implementation deficit disorder not only in the health service but in the

Oireachtas as well and we do not know how to follow through on the best available advice.

I thank Dr. Peadar Gilligan and Ms. Susan Clyne of the IMO, Ms Phil Ní Sheaghdha and Ms Martina Kelly of the INMO, and Dr. Donal O'Hanlon, Mr. Martin Varley and Dr. Laura Durcan of the IHCA for their expert comments and advice and for giving us their time.

The joint committee adjourned at 1 p.m. until 9 a.m. on 19 September 2018.