DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 3 Deireadh Fómhair 2018

Wednesday, 3 October 2018

The Joint Committee met at 9 a.m.

MEMBERS PRESENT:

Deputy Stephen S. Donnelly,	Senator Colm Burke,
Deputy Bernard J. Durkan,	Senator Keith Swanick.
Deputy Alan Kelly,	
Deputy Margaret Murphy O'Mahony,	
Deputy Louise O'Reilly,	

DEPUTY MICHAEL HARTY IN THE CHAIR.

Business of Joint Committee

Chairman: I have been made aware that the recording continues from 9 a.m. onwards so if members are having conversations, they should be aware that a recording process is ongoing.

Deputy Stephen S. Donnelly: Are we covered by privilege?

Chairman: I propose that we deal with housekeeping matters in private session. I just ask members to be aware of that.

The joint committee went into private session at 9.06 a.m. and resumed in public session at 9.40 a.m.

Sláintecare Implementation Strategy: Discussion

Chairman: In our first session, we are meeting the Minister for Health, Deputy Harris, and his officials, and Ms Laura Magahy, the recently appointed executive director of Sláintecare regarding the Sláintecare strategy. On behalf of the committee I welcome the Minister and Ms Magahy to the committee.

I draw attention to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. However, if they are directed by the committee to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise nor make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. I also advise them that any opening statements given to the committee may be published on the committee's website after the meeting.

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

I call the Minister to make his opening contribution.

Minister for Health (Deputy Simon Harris): I thank the Chairman and the committee for the invitation to discuss the implementation of Sláintecare. I am pleased to be joined by Ms Laura Magahy, who was recently appointed as executive director of the Sláintecare programme office. She was appointed following a comprehensive recruitment process and brings a wealth of experience to the role. I formally welcome her to the position and assure her of my full support in this challenging but exciting role. She took up the post officially on 1 September and has hit the ground running since then. I will ask her to outline her immediate plans for implementation and progress to date shortly.

Just as the Government and I value the cross-party support that produced the Sláintecare report, we recognise that the same support and cross-party co-operation will be required to successfully deliver the Sláintecare implementation strategy. Every party and grouping in the

Oireachtas, bar perhaps one, has said that it is in favour of Sláintecare and the implementation thereof. We need to all work together now to make that a reality. As I have said to this committee previously, we will only succeed in bringing about change if everyone, including politicians, clinicians, patients, service users and others, is united on the overall goal and we are all pulling in the same direction.

The publication of the Sláintecare implementation strategy in August marked another important step in this process. The strategy provides an implementation framework for the transformation process and it outlines 106 specific actions that will be taken over the next three years, which are the first three years of the strategy. I firmly believe that this process is different from others that came before it because this is not my plan and it is not just the Government's plan; this is the long-term plan, everyone's plan and the only plan. Change of this magnitude cannot be delivered overnight and it is important that we acknowledge this is a strategy that will take time to implement. The publication of the strategy was an important step, but this is a process that will have many steps over its lifetime. We have also paid particular attention to getting the implementation governance and structures right, which was rightly important to the Committee on the Future of Healthcare. In the past, this has been lacking. We have had many strategies previously and the lack of an implementation structure has often caused challenges. I will return to this later.

We are committing to the development of detailed action plans each year and we will measure our progress transparently with twice-yearly progress reports. This is a new departure in health reform and we are trying to use a model that has been used in the Action Plan for Jobs, for example, where we will not just say that we will do something but we say that we will do it and then report against it. Every six months, we will publish a progress report to show what we said we would do, who we said would do it, to check if it is done and if so that is great but if it is not why is it not done. That transparency in reform is something that has been lacking in our health service over many years and it is a focus that I hope we can bring to it.

The Sláintecare report will be delivered over a 10-year period and, at its core, it will do a number of things. It will move our system to a population-based approach of healthcare planning and delivery. This will involve the development of a citizen care master plan for the health service, which will inform service planning, resource allocation, workforce planning and policy prioritisation. This is important because, in the past, we have tried to develop the health service to suit the health service. It was the system for the system but what we are trying to do now is find out what services our citizens need, what is the citizens care master plan and then put the structures in around that rather than the other way around. Informed by this framework, new models of care will be designed that are structured, coherent and tailored to population need. It will continue the focus on promoting the health and well-being of our population through the implementation of Healthy Ireland, the framework for improved health and well-being. A priority action is the publication of the Healthy Ireland outcome framework this year.

A significant part of Sláintecare will be the focus on bringing the majority of care into the community. This will require a much stronger system of community care, with increased resources and an expansion in the range of services that are available. The initial focus will be on developing capacity to manage chronic disease in the community, development of community intervention teams, which we have made some progress on by increasing investment in, and access to, community-based diagnostic facilities and the development of community nursing services. We will also move towards a health service where care is provided on the basis of need and not on the ability to pay. This ambition must be planned carefully and introduced over

a period that is appropriate in terms of making sure we have the workforce and the investment in place. If we get the sequencing of this wrong, all we will do is end up rationing care in the community rather than ensuring that people can access it. Progress is being made in extending entitlement, including providing medical cards to those in receipt of domiciliary care allowance, and GP visit cards to those in receipt of carer's allowance. The Government has also committed to the introduction of a statutory scheme for home care to support people to live in their own homes. It is my intention that this scheme will be operational within this first three-year period of the strategy under discussion today.

Under Sláintecare, we will move our system from long hospital waiting times to a timely service, especially for those who need it. There is no single solution to this but additional bed capacity both in hospitals and the community is a big part of it, along with investing further in home care services, multi-annual plans for reducing waiting times and considering how best to introduce a waiting time guarantee. One development that I believe will be significant, which is mentioned in the Sláintecare report, is the development of elective hospitals. We have funding to deliver three elective hospitals with one each in Galway, Cork and Dublin.

I had the opportunity to visit Golden Jubilee Hospital in Scotland just last week with Ms Magahy to see exactly how an elective-only hospital was developed. The good news is that the hospital administrators have managed to significantly reduce their waiting lists. When the hospital first opened, people were waiting three years for a hip or a knee replacement but that is down to 12 weeks while people were waiting two or two and a half years for cataract surgery but that is down to an average of four weeks. We must move on with the development of our elective facilities. We have seen that it has worked in Scotland and we now need to reproduce that model here. We will pick the sites for these three hospitals next year. Our focus is always on driving down waiting lists and ensuring patients can have access to services as soon as possible.

Sláintecare will also bring about improved governance, performance and accountability, which is something that this committee spends a lot of time talking about and scrutinising for very good reason. This will be achieved through the establishment of a HSE board, defining new organisational and operational structures for the future reconfiguration of the health services. The HSE board legislation will be introduced in the Seanad on 10 October and I hope to pass it through both Houses of the Oireachtas this year with everyone's co-operation so that it can take effect at the beginning of next year. I was pleased to announce Mr. Ciarán Devane as chair-designate of the new board. He brings a wealth of experience to what will be a challenging role and I look forward to him having an opportunity to come before the committee to be scrutinised on his views and plans for that role.

I have mentioned the importance of implementation governance and structures and I would like to briefly outline a number of key elements. There is widespread agreement that significant change and reform requires a well resourced programme office to champion, lead and manage the process. The Sláintecare report recommended the establishment of such an office and a Sláintecare programme office has now been established. It will be led by Ms Magahy and it is being resourced with the skills and expertise necessary to lead the reform programme. The programme office is, as I said in August, working on a detailed action plan which will be published before the end of the year. This will include a review of all the actions and associated timeframes, the development of detailed milestones and, crucially, the assignment of responsibility for each action. In the Sláintecare report produced by the committee, it asked that when we published the plan, it would then be reviewed by the executive director. That is the process

we are undertaking and it will be published by the end of the year.

There are two other structures which I wish to draw to the committee's attention. The first is the Sláintecare advisory council. It is important that we get the stakeholders and ask experts here to help us out in the delivery of this plan because it cannot be something merely owned in the Oireachtas or in the HSE. I am eager that an advisory council would be in place. I am delighted that it will be chaired by Professor Tom Keane, an eminent clinician and clinical leader, who came to our country and worked with my predecessors and previous Governments to reform our cancer services, and we are seeing the benefit of those outcomes today. I am delighted that he has agreed to lend his services to Ireland again.

Professor Keane will chair the advisory council. It will comprise 23 members. I am pleased to be in a position to announce the membership of the council. For the record of the committee, the membership is: Professor Tom Keane, the former director of the national cancer control programme; Ms Laura Magahy, executive director; Dr. Siobhán Kennelly, consultant geriatrician; Dr. Anthony O'Connor, consultant gastroenterologist; Professor Patrick Broe, general surgeon in Beaumont Hospital and clinical director in the RCSI group; Dr. Colm Henry, chief clinical officer of the HSE; Ms Annette Kennedy, president of the International Council of Nurses; Dr. Ronan Fawsitt, a GP in Kilkenny who has done excellent work in the development of primary care; Ms Gillian O'Brien, director of clinical governance at Jigsaw; Ms Róisín Molloy, an incredible patient advocate with a wealth of experience in this area; Mr. Brendan Courtney, a patient advocate who shone a spotlight on the importance of getting home care and looking after our older citizens' rights in this country; Ms Sarah O'Connor, CEO of the Asthma Society; Mr. Brian Fitzgerald, former CEO of St. James's Hospital and deputy CEO of the Beacon Hospital; Mr. Liam Doran, former general secretary of the INMO; Mr. Leo Kearns, CEO of the Royal College of Physicians of Ireland, RCPI; Dr. Josep Figueras, who, I believe, appeared before the Committee on the Future of Healthcare and is a director of the European observatory; Ms Joanne Shear, former national primary care clinical programme manager at the US Veterans Health Administration; Dr. Heather Shearer, clinical governance expert; Dr. Eddie Molloy, management consultant; Mr. Paul Reid, CEO of Fingal County Council, who brings a wealth of experience in change management; Professor Mary Higgins, obstetrician, National Maternity Hospital; Dr. Anna McHugh, GP registrar, Donegal; and Dr. Emily O'Conor, president of the Irish Association of Emergency Medicine and a consultant in emergency medicine at Connolly hospital. The committee is almost gender balanced, with a split of 12 to 13. There are a wide range of skill sets, from a patient advocacy point of view, from a change management point of view and, importantly, from a medical point of view. I thank those people for stepping up and serving, and offering us their wealth of experience. The first meeting of the advisory council will take place, and be chaired by Professor Keane, on 24 October. I hope this committee will at some point have an opportunity to engage with him on his role and how he envisages the advisory council helping us deliver it.

The second structure is the high-level delivery board. This will comprise the Secretaries General of the Departments of the Taoiseach, Public Expenditure and Reform and Health, the director general of the HSE and the Sláintecare executive director. This is important. The Committee on the Future of Healthcare stated that it wanted a whole-of-government approach to this and having a high-level delivery board that the executive director can feed in to and that can then feed in to the Cabinet Committee on Health, chaired by the Taoiseach, is crucial. Having in the room the Secretaries General of the Departments of the Taoiseach, Health and Public Expenditure and Reform is important and very much in line with the committee's strong recommendation on the need for cross-government support.

We have begun progressing a number of recommendations. We moved ahead with the establishment of the HSE board. That legislation will commence in the Seanad next week and I would appreciate co-operation on that.

Crucially, we have carried out a public consultation on the geo-alignment of hospital groups and community healthcare organisations. This has been completed and I will publish the results shortly. I want to move ahead with outlining what geo-alignment will look like this year and I will need the committee's support on this. Drawing lines on maps is never the easiest exercise for any politician to do. The Sláintecare committee helpfully left it to my Department to work out how best to divide up the country, but what the committee was keen on, and what I am keen on, is that we move away from this siloed approach that there are duplicate management structures for community care and hospital care. If we are to deliver Sláintecare, we need geo-alignment. We need a singular budget for a certain part of the country to deliver the whole spectrum of care. That is what we need to get to.

I have taken the decision, in consultation with Ms Magahy, to move forward on that at a quicker pace than originally envisaged and I intend to announce my proposed geo-alignment this year. This is the potential game-changer that the committee wants to see in terms of Sláintecare because one can no longer have siloed budgets with somebody saying that patient X needs to remain in the hospital because it will cost him or her to care for that patient in the community or *vice versa*. One budget with a board for each regional entity holding people to account at a regional level is an important way. It will help deliver integrated care. However, if we are to legislate for this, I will need cross-party support to deliver this. I would be happy to discuss with the committee the public consultation document in advance of that or to send that to the committee so that it could consider it. I would very much welcome, in the spirit of bipartisanship, the committee's consultation.

The Committee on the Future of Healthcare was also clear on the role of private practice in public hospitals. Let me be clear, because sometimes I hear myself described by my opponents wrongly in this regard, I am in favour of the removal of private practice from public hospitals but, like the Sláintecare committee, I am in favour of doing so in an intelligent, phased way. I have made my views on this quite clear. Our current mixed model system is an outlier. We cannot convince ourselves it is the norm. It is not the norm. It is an outlier that one can have a public hospital full to capacity and a patient who is in greater need of care not getting that care because somebody is carrying out private practice in that hospital. We cannot stand over that, but we also have to do it right and we cannot do it overnight. The committee asked me to set up an independent review group to examine the impact of separating private practice from the public hospital system. I have done that and it is being chaired by Dr. Donal de Buitléir. The work is ongoing and I expect to receive that report by the end of this year or shortly thereafter. This will provide valuable guidance and I would welcome an opportunity to discuss with this committee. However, my policy objective is clear. I believe we need to remove private practice from public hospitals but we need to do it in a way that makes sense.

I will briefly refer to the role general practice needs to play in this. We cannot deliver a decisive shift to primary care or community care and more services if we do not resource general practice. The committee will be pleased to hear that I have reached agreement with the Minister for Public Expenditure and Reform on significant multi-annual funding for general practice and I expect intensive engagement to commence on this matter in the next few weeks.

Finally, I have mentioned capacity. The health service, even when one implements reforms, does not have adequate bed capacity. We do not compare favourably internationally in this

regard. The Government's national development plan, NDP, commits €10.9 billion, much of which is directed at Sláintecare. This will include 2,600 additional beds, the elective hospitals I mentioned and 4,500 community care beds that have been identified. It will also include the roll-out of eHealth, which is so important and which was a key recommendation of Sláintecare, and putting diagnostics into our primary care centres. There are 124 primary care centres in operation throughout the country. The key now is what more can they do. Can we put more X-ray facilities, more ultrasound facilities and more staff into these facilities? I am pleased that the development plan will deliver that.

I am confident that the plan that many members in this room worked so hard on and engaged on for such a long period of time is the right plan and that if we implement it, we will very much be on the right track. We agreed on a vision and we now have an implementation strategy. We have dedicated staff, led by Ms Magahy, to deliver and implement this strategy. We will report twice a year. We will publish detailed annual action plans and resource this through the budgetary process as well. This will require a broad coalition of support and I look forward to working with all stakeholders on the important agenda.

With the Chairman's permission, I will ask Ms Magahy to say a few words.

Chairman: Ms Magahy can make her opening remarks.

Ms Laura Magahy: I thank the Chairman and the members. I very much look forward to working with all of them over the next number of years to deliver on the Sláintecare objectives and on the principles outlined in the original Oireachtas report.

The robustness of the Sláintecare structure gives a sound underpinning and I suppose I am the little circle in the middle. The implementation office is in the middle and will be supported by the advice from the advisory council, which I very much welcome, reporting through to the other structures that the Minister has outlined. I believe it gives a strong link back through to the system, and down and out to the people who are delivering the services.

The remit of the programme office is to establish the programme of reform to develop a strategic and programmatic approach to implementation working with all parts of the system to ensure that everybody is following the strategy and to work collaboratively with all the stakeholders, support the work of colleagues in their reform efforts and report progress. I am keen not to duplicate any effort that is under way and, therefore, I proposing to have a small tight office, which then connects to the people who are doing the work, and to have a strong focus on implementation. I am mindful that everyone here has a part to play in the delivery of Sláintecare. Key to its delivery is continuing political buy-in and the leadership that was shown by the cross-party Oireachtas committee. That support is very important to me while the implementation process is going on, and I look forward to working with the members of this committee. I hope to continue to have their support. I am very happy to meet the members individually if they would like more details on what I am proposing. I encourage them to get involved in the process.

Citizen engagement and empowerment is key, and I am beginning a programme to that end before the end of this year. It is essential that there is buy-in to this process. Enabling those on the front line who are delivering services is also key, and also the wider determinants. We tend to focus on the HSE and those structures, but we need to involve the wider determinants for prevention purposes, in particular, for the health and well-being of people. It is something that I am going to be focusing on. We will take a partnership approach.

I have been in office for 23 days, so I am very new to the role-----

Deputy Alan Kelly: That is a long time.

Ms Laura Magahy: It is a long time in politics, but not a long time when one is implementing a ten-year strategy. The office was established, and I am now engaged in beginning discussions with people about what is important to them and identifying their priorities. Key to my job is to come back before the end of December with an action plan for 2019 setting out who is doing what, where, when and how. That is what I am focused on. There are 106 actions in this strategy, and I am intent on delivering within the set time limits. The advisory council has been established and it is meeting for the first time in October. I have finalised my approach to the citizen care master plan, and the citizen engagement and empowerment process will roll out before the end of the year. The budget is under discussion at the moment.

I thank the committee for the opportunity to meet it. I look forward to working with it.

Chairman: I thank the witness. Every member will have seven minutes to interact across the floor. We would appreciate it if members could be concise with their questions, and perhaps the Minister would be concise with his answers so that we can move along speedily.

Why was the Sláintecare office not set up in the Department of the Taoiseach rather than in the Department of Health, as recommended in the Sláintecare report? Given the nature of building in Ireland, particularly the building of hospital beds, when does the Minister expect the first new hospital bed to be built and available? I understand that most of the capital resources are going into the completion of the children's hospital at the moment, which will not be completed until 2021 or 2022.

Why is there no reference whatsoever in the Sláintecare implementation strategy to the setting up of a national health fund, which was a central component of the Sláintecare recommendations on how this would be funded going into the future?

Deputy Simon Harris: The question as to whether the office should reside in the Department of Health or the Department of the Taoiseach was discussed at this committee, and I made my views very clear on that at the time. The Minister for Health is accountable to the Oireachtas for the delivery of the health service under Sláintecare, subject to the health Acts and the powers and functions of the HSE. The Minister for Health is also accountable democratically in terms of answering parliamentary questions, Topical Issue debates, Private Member's motions and legislation. To hive off responsibility for reform of the health service from the Minister for Health of the day would have been a very peculiar construct, in my view, and the view of the Government, taking into account the Ministers and Secretaries Act 1924. We made sure there was a structure in place to try to achieve the same objective. I flagged that with the Sláintecare committee in advance of publication and at this committee post publication. People can agree or disagree that we have achieved that, but it is what we endeavoured to do. Ensuring that there is a high-level delivery board involving the three secretaries general of the crucial Departments - the Department of the Taoiseach, representing the Taoiseach of the day, the Department of Health, representing me, and the Department of Public Expenditure and Reform in terms of resourcing - is the way to go. The Taoiseach will chair the Cabinet committee on health, and the Sláintecare office, including Ms Magahy and me, will account to the Taoiseach.

The question about beds is very valid. I can assure the Chair that I ask that question several times a week. I asked the HSE to produce a document detailing the number of beds it could de-

liver over the next three years using a combination of modular build, existing space in hospitals and a degree of internal reconfiguration to make more space or to use space more efficiently within hospitals, and it has responded, stating that it could deliver around 600 hospital beds. I can send the Chair a detailed note, because I do not have the exact details to hand, but the answer to the question asked is that over the next three years approximately 600 of the 2,600 beds can be delivered. A big chunk of those beds will be delivered towards the latter half of 2019. The Chair is familiar with Limerick, geographically and medically. Delivery of modular builds would create 60 beds for University Hospital Limerick. I am very committed to doing that, and I have discussed it with the CEO of the hospital group. That is an example of the delivery of the first tranche of 600 beds.

It was decided, when we published the implementation plan, not to make any decisions that are matters for the budget outside of the normal budgetary cycle. However, we will require an integration fund for the delivery of Sláintecare. There is a lot of funding in the Department of Health already, and any extra funding through the budget will be Sláintecare-proofed. Almost €11 billion has been allocated in the capital plan. My analysis of the plan suggests that €6.6 billion of that is for Sláintecare, whether through elective-only, diagnostics in the community, bed capacity in the community hospitals or eHealth. Above and beyond that, I have to empower Ms Magahy and her team to deal with the large-scale roll-out of projects to take services from the acute hospitals into the community. The Sláintecare advisory council will assist in that. The Sligo eye care model is one that people often talk about. It has been piloted for so long that everyone accepts that it works. At what point can we roll it out? In Deputy Kelly's constituency there is the Nenagh cataract theatre. If it works in Nenagh, we should be able to roll it out nationally. We know that community intervention teams, CIT, work, and they should also be rolled out nationally.

Chairman: I want to keep the meeting moving. Sláintecare recommended that funding would be allocated to the plan annually, providing between €306.85 million to €450 million to cover the expansion of entitlements and a €3 million transition fund to make up for the lack of infrastructure over recent years. However, in the implementation strategy there is no reference to funding whatsoever. A reference is made to an integration fund, but no value is put on that fund.

Deputy Simon Harris: The Chair is correct.

Chairman: How can the Minister give us confidence that funding will be made available to implement this strategy?

Deputy Simon Harris: The Chair has identified an issue that will have to be addressed as part of the normal budgetary process. When the implementation plan was launched in August, I made the point that the Government has decided that the resourcing of Sláintecare, which is something in which all political parties have a role to play in a minority Government, is a matter for the Estimates process. The budget is next week.

Deputy Stephen S. Donnelly: I welcome the Minister, and I wish Ms Magahy the best of luck. She has taken on a Herculean task. Fianna Fáil has signed up to Sláintecare. It helped to write it and would like to see it implemented.

Healthcare reform is difficult and complex and regularly fails in different jurisdictions around the world. One of the things it requires is credibility of leadership, and I am worried by parts of the statement the Minister has made. Understandably, he is looking to the future, but

there is no reflection on the problems we have at the minute. Since 2011, healthcare spending has gone up every year, per person and when adjusted for inflation, and yet waiting times across the board for men, women and children all over Ireland are worse than ever. For the third year in a row there has been a massive budgetary overrun and it is fair to say that clinicians all over the country are at their wits' end.

I will focus on waiting times because the issue affects patients the most. Children with special needs are waiting three and half years for treatment. Young children with scoliosis are waiting three years for treatment. In the rest of Europe spinal curvature is not allowed to exceed an angle of 45 degrees but in Ireland the limit is 100 degrees. For the first time ever, the number of people on waiting lists has exceeded 1 million. When one adds the National Treatment Purchase Fund, NTPF, figure to all the other figures, the number totals 1 million people, which has never happened before. In spite of annual increases in funding, the position is worsening. Let us take the number of people waiting for surgery for more than a year. In 2010, that figure was slightly more than 700 people but now stands at 14,000. For every one person in Ireland who was waiting over a year for surgery in 2010, there are now 20. This goes to the heart of credibility.

My real fear is that the responsibility for fixing these failures is now being put on Sláintecare. The presentation lists seven Sláintecare objectives. I will not read them all but I put it to the Minister that four of them should have nothing to do with Sláintecare as they are the job of government. Promoting the health of our population is normal healthcare. Moving our system from long waiting times to a timely service has nothing to do with Sláintecare and is the job of the Government. Waiting times were falling drastically and were 20 times lower in 2010 than they are now in certain areas. Accountability and performance is also the normal job of healthcare management. I am concerned that there is a lack of acknowledgement of just how bad things have become in healthcare for patients and clinicians. Sláintecare is being given the role of system reconfiguration and moving to a more modern model of care. That is its responsibility but I am concerned that Sláintecare is being tasked with fixing the problems that are the normal job of Government to fix, for example, waiting times and avoiding significant budgetary overruns every year.

In the spirit of trying to get this right, does the Minister accept the failures in the healthcare system today, particularly in terms of waiting lists which are longer than they have been since records began? Does he agree that in order to implement a very serious and ambitious programme of change, we will need much more competence in delivery by Government based on what patients are facing every day? How does he plan to provide that competence given that what we are facing and what we have all signed up to is a complex, difficult and important programme of change?

Chairman: Deputy Donnelly has taken four minutes. I do not know if the Minister can respond in three minutes.

Deputy Simon Harris: I will do my very best. I thank Deputy Donnelly. Certainly, when I look to reform I will definitely look to the future and I will not the past. The way that people have endeavoured to reform the health service has created many of the current problems. The establishment of a national entity, an idea most political parties agreed with, was botched. As a result, we have layers of bureaucracy that often make it impossible for citizens to find answers. I welcome the cross-party approach to how we should reform the health service in a way that is very much better than the reforms that have gone before.

Deputy Donnelly listed a number of objectives which he claimed have nothing to do with Sláintecare. They are very much in the programme, as the Deputy knows. Sláintecare deals extensively with the issues I raised in connection with waiting lists and calls on me to address them. What I am doing is accounting to this committee today for my intention to do that.

I do not accept the Deputy's assertion that everything in healthcare has worsened. It depends on what one measures. For starters, let us talk about waiting lists. Some of the figures now published on waiting lists were not published before the Government took office. Outpatient figures were not published before 2014. When speaking about current figures the Deputy is not comparing like with like. There are challenges in terms of waiting lists. In line with a commitment agreed by Deputy Donnelly's party and my party in the confidence and supply agreement, the number of people waiting for inpatient day-case treatment has fallen by 13,000.

Outpatient services are a major challenge. One of the main ways to address the issue is through the Sláintecare model by identifying who can be seen locally in the primary care centre by a general practitioner or an advanced nurse practitioner. Many of the metrics are much better than previously. I do not suggest the Deputy did this but blaming Government policy for all of the failures in the health service and crediting everything but Government policy and investment for everything that is good in it does not stand up to scrutiny. Children with cystic fibrosis will, thank God, live an awful lot longer than they would have done heretofore. That is as a result of great clinicians but also the significant investment we have made in drugs such as Orkambi. The same applies to outcomes for cancer, stroke, heart conditions and life expectancy. While having one person on a trolley is one too many, the HSE TrolleyGAR number fell by 5% in September.

I accept that there is a substantial body of work to do and very many challenges in healthcare. However, I do not accept that everything in healthcare is in crisis because every single day many people have a positive experience. We surveyed patients who stayed at least one night in an acute adult hospital last year. When we asked how they found their experience from the moment they walked into the emergency department to the moment they were discharged, 86% of respondents indicated their experience was good or very good. However, I need to be worried every moment of every day about the 14% who did not have a good experience. If we are to address that issue, we need to implement Sláintecare.

The Sláintecare plan has credibility because it has something we have never had before in healthcare. First, all of us support it but, more important than the political support for the plan, it has a decent chance of being given the time it will need to function. In case Deputy Donnelly is ever appointed Minister for Health, I should point out that what people in the health service despair about is another new Minister arriving with a bright shiny plan. We now have one plan and we are all pulling in the same direction. It will require resources. To answer the Deputy's question on delivering Sláintecare and accountability for its delivery, as the Minister for Health, I am accountable for delivering it. Ms Magahy is charged with running the Sláintecare office but I am accountable to the Oireachtas for the delivery of this plan. If we publish an action plan at the end of this year and say we will do this, that and the other and report against that every six months, I will be accountable to the Deputy and he people of Ireland for achieving those commitments.

Deputy Stephen S. Donnelly: The short version is as follows. My concern is that Sláintecare will be tasked with solving problems such as waiting lists. We do not need Sláintecare to reduce waiting lists, promote the health of the population, drive accountability and performance or deliver a healthcare system that has the ability to plan and execute. We need Sláintecare for

reconfiguration. Reducing waiting lists and helping the men, women and children on those lists have nothing to do with Sláintecare. Most of these problems have worsened in recent years.

How much money will the Minister seek explicitly for Sláintecare activities over the next one to five years, as opposed to the normal expected increases in healthcare expenditure that we would expect to see?

Chairman: I urge the Minister to reply in one minute, if possible.

Deputy Simon Harris: We will not have time for a back and forth debate. While I take the Deputy's point, I do not agree that Sláintecare is not the key to addressing many of these challenges, including waiting lists. Delivering what Sláintecare calls on me to deliver is key.

With one week to go before the budget, I cannot answer the Deputy's question on how much I am seeking, or perhaps his party is seeking, in the budget for the delivery of Sláintecare. I can give one example of multi-annual expenditure. Of almost €11 billion provided for capital expenditure, €6.6 billion is what I would describe as Sláintecare funding for the delivery of its capital elements. The current expenditure elements will be a matter for budget day next week and the HSE service plan thereafter. I will be happy to continue our interaction on the Deputy's questions later.

Deputy Louise O'Reilly: I welcome the Minister and Ms Magahy and wish her the best of luck with the task ahead. There is an awful lot riding on the Sláintecare plan.

I listened to the previous exchange on which Government made the biggest mistakes in the health service. We could play that game all day but it probably will not advance the discussion. The Irish Nurses and Midwives Organisation, INMO, has measured trolley waits for a long time and its figures do not always concur with the figures produced by the HSE's TrolleyGAR. The INMO figures show the position is getting worse. Will the Minister confirm that the overspend and the carrying over of recurring expenses will be addressed in the budget? We talk about investment but months after the previous budget the Minister received a letter from the head of the HSE saying that it was in trouble as a result of underfunding. Deputy Pearse Doherty pointed that out to the Minister but he did not listen. Maybe he listened this year, and I hope that he did. Will he confirm that?

Deputy Simon Harris: Sure.

Deputy Louise O'Reilly: On the transition of services to primary care, much of our primary care is centred around GPs. I have seen no evidence that any progress has been made on the renegotiation of the GP contract. Will the Minster update us on where that process has reached? I have repeatedly asked questions about staffing for primary care centres, and each time I receive the same answer. It is a real cut and paste job which says services will be provided from within existing resources. I can even quote it from memory. There are no new staff. If the Minister has a vision for how this will work without staff, I would love to hear it. I doubt he does, however, so we must hear about where the staff are going to come from and, specifically, what the Minister will do in regard to GPs.

Sláintecare provides that there will be legislation for entitlement for all residents to access health and social care and a guarantee on waiting lists underpinned by legislation. The implementation plan has changed that slightly and uses the words "expand eligibility on a phased basis to move towards universal healthcare". If it is universal, then we do not have to discuss eligibility. There seems to be some contradiction. There has also been some slippage with the

universality but also the legislation to underpin guaranteed waiting times. I echo the previous comments. It is very much bound up with the waiting lists, because it is a mechanism, but the waiting lists must also be addressed separately.

Will the costings that the Department of Health will use in the implementation strategy be published along with the implementation report? It is important that we see that and that we see real progress. No one wants this to be merely a tick-box exercise.

Deputy Simon Harris: I will ask Ms Magahy to come in on the matter of workforce planning in a moment. On the overspend, as my colleague, the Minister for Finance and for Public Expenditure said, possibly at a Committee on Budgetary Oversight meeting last week, he and I are actively engaging in addressing what will be a requirement for supplementary funding for the health service this year. I am very confident that we can reach agreement on that. That issue will crystalise and I expect that it would be resolved in the next few days.

I would need to come back for a separate session on overspend versus value for money because I could use almost my seven minutes on that. There is a need for accountability on the resources that are given and a need to ensure that we have an adequate budget each and every year within the resources available.

On GPs, as I said in my opening statement, in recent days I reached an agreement with the Minister for Public Expenditure and Reform which gives me a mandate to engage with GPs on a multi-annual investment programme. It is a very substantial programme, both as the subject of negotiations and the budget, so I cannot be more specific. That said, I genuinely expect very intensive engagement in coming weeks with GPs and I expect to be in a position to be able to increase significantly the investment in general practice starting next year, subject to agreement.

The Deputy, to be fair to her, regularly raises the issue of the staffing of primary care centres. I will see if we can get the Deputy some specific information on this. When I open primary care centres, I am regularly told about the additional staff working there and the additional specialties being undertaken. I will try to get Deputy O'Reilly a note and will be happy to come back and debate that with her.

Deputy Louise O'Reilly: The Minister could just inform the officials in his Department because I could paper the walls of this room with the responses I have received and they all say the same thing. There may be new staff moving in from other areas, say in Balbriggan, where they closed the health centre and moved them into the new health centre, but that does not represent additional staff for a town with the fastest growing population in the State. That is only shifting staff around. No new services can be developed just because someone is taken out of a building that is derelict and put them into one that is shiny.

Deputy Simon Harris: I take that point. I would point out, however, that there were extra occupational therapy posts this year, extra speech and language therapy posts recently, and more than 140 assistant psychology posts. I will ask Ms Magahy to do some work on that. I also ask her to speak about how we will plan for the workforce for the delivery of Sláintecare.

Ms Laura Magahy: The Deputy has raised a very interesting question about what the new model of care will look like when we move care that should not be in hospitals more into the community. It is around the needs of the population, and that is what the geoalignment will facilitate. It will need a combination of approaches based on whatever the needs are. We will talk to the different training bodies about training extra GPs and practice nurses, for example,

training advanced nurse practitioners, ANPs, and community nurses, and cross-training for multidisciplinary team approaches, and about trying to get that in the colleges at an early stage rather than everyone being trained in their own specific area and then being expected to work in a multidisciplinary way later, by miracle. There is also clinical managerial training. We are starting to engage younger professionals and enlisting their views, because of the disaffection that many have expressed about working in the system, to hear what they have to say. It will have to follow the model of care and what that will look like when we start to move types of work which are taking place in the hospitals into the community.

Deputy Louise O'Reilly: I asked a very specific question about where the legislation to underpin waiting times has disappeared to, and the worrying move from universal access to expanding eligibility. It is in the Sláintecare report but it is not in the implementation plan. I am conscious of time and do not want to eat into others' time.

Deputy Simon Harris: This is something I and Ms Magahy have discussed in recent days. I agree with Deputy O'Reilly on the word "entitlement" rather than eligibility and we will revert to using entitlement. The idea is that every citizen in this country should be entitled to access care in their community. We want universal entitlement and universal access to primary care.

The second thing is important, and is outlined in actions in section 6.2 of the 106 actions that we published. Sláintecare does say that it should be low cost or no cost. That is a direct phrase in the report, and Sláintecare refers specifically to that. Actions 6.2.1 to 6.2.3, inclusive, outline three very specific actions that we will undertake in establishing the framework and developing the roadmap for achieving universal access, both of which will start next year. That is still the position.

We are committed to guaranteed waiting times. The implementation plan is committed to doing that.

Deputy Louise O'Reilly: Will the Minister point out to me where that is because I did not see it?

Deputy Simon Harris: I hope that I am right, but we will legislate. I will come back with the specific number in one moment. However, I do want to legislate for waiting times. I spoke to the Scottish health minister about this last Friday. I want to do it and make sure that we can deliver them. The elective-only model was how they did it in Scotland. We have given a commitment to picking three sites next year for the delivery of elective-only hospitals. I want to see if we can move ahead more quickly with one of these so that we have a demonstrated project, and then we can legislate for the waiting times. However, I need to ensure that the capacity is there before legislating for the waiting times. I will return to the Deputy in a moment about where this is written.

Did the Deputy ask me another question?

Deputy Louise O'Reilly: I asked about publishing the costing along with the review and the updates.

Deputy Simon Harris: Each year we will have to say what we are doing the following year and show how much it will cost and how we will deliver it, so yes that is the position about annual plans.

Deputy Louise O'Reilly: Excellent.

Chairman: Is the Deputy happy with that?

Deputy Louise O'Reilly: I am ecstatic, Chairman. I am a happy person.

Deputy Alan Kelly: I thank the Minister and Ms Magahy. I do not know whether I should congratulate Ms Magahy or say, "Sorry for your troubles."

Ms Laura Magahy: All our troubles. A problem shared.

Deputy Simon Harris: Before Deputy O'Reilly leaves, the particular action is 5.1.6. I apologise to Deputy Kelly.

Deputy Alan Kelly: That is okay. I wish Ms Magahy the best of luck.

Ms Laura Magahy: I thank the Deputy.

Deputy Alan Kelly: I do not have too many questions but they are quite specific. The first is directly for Ms Magahy and relates to her. I do not know how many people in this room were involved in writing the Sláintecare report. To be fair to the Minister, the specific structures put in place - the advisory council, where it fits within Government, structures and everything like that - are those for which we asked. What is the programme office going to have as its own resources? Ms Magahy referred to a small team earlier on; what is it? Within those structures there is no doubt that there will be frustrations from time to time, dare I say some of them with the man sitting beside Ms Magahy or whoever is in his role. How is she going to deal with them? How is she going to ensure she can get traction within the structures that have been put in place when she is missing deadlines, timelines are not being put in place, and resources are not available? There will be absolutely an element of that. How is she going to use those structures and what is she going to do to ensure that she is getting what she wants when she wants it?

On the 106 actions, there is the whole area of the first number of years and prioritisation. For instance, one of the biggest priorities, which I insisted on, was bringing forward community care, all the issues in respect of home help and the whole range of stuff there, which is common sense, as well as bringing forward diagnostics because it is creating blockages all over the place. I know she is only in her role 25 days, but could Ms Magahy use that as an example in her answer as to how the programme office is going to interact within the structures to make it achievable within the three-year timeframe?

My next question is for the Minister and concerns the hospital capacity review and its implementation. I think I must thank him for his news, as he more or less said the 60-bed unit in Limerick is to be part of the plan he is going to announce. I appreciate that he has confirmed that. With Clonmel and Limerick on either side of me, I get the benefit of having the two worst situations as regards accident and emergency departments and people on trolleys in the whole country. On the actual capacity, I presume there will be some process whereby the alignment of this work with the alignment of Sláintecare is going to be engineered because that is critical.

The Minister might outline a little bit more - best of luck with this one, I mean that in jest - the whole issue of geo-alignment. He said he had timelines for that, what are they? Again I agree with him that it has to be brought forward. I do not think Ms Magahy's work can progress until that alignment happens.

When will the report from the committee of Dr. Donal de Buitléir be available in respect of public-private? The Minister made a statement about GP contracts, I presume in respect of

multiple annual funding. Senator Swanick will probably have questions on this. We all know the level of progress is not what it should be. Is the Minister saying that since he has got this agreement now, he is going to see progress moving at a different pace imminently?

Ms Laura Magahy: In terms of resources, I have outlined four work streams of how I am going to structure my 106 actions. This is just work in progress. The first is around the citizen care master plan, so I will need population health planning expertise as part of my team but will also be working out in the system with people who have that expertise. In terms of co-ordination, governance and value for money, which is my second work stream, I will need finance and governance advice coming into my team. My third work stream is about teams of the future and I have talked a little bit about that; obviously, I will need workforce planning expertise. Finally, I have the sharing progress work stream which is about communications and engagement. Through those, we have some service design people, some project managers, critically. I will also need input from different people at different points in time, for example with an economics background or whichever pieces are needed at the time. Between now and the end of the year, I am working out how the action plan is going to be structured and what my team is going to be in-house. I am going to keep it tight because there is expertise out in the system and I am proposing that the office is a kind of bridge out to the system just to make sure everything is co-ordinated and happening in the right sequence. I hope that answers the Deputy's question.

Deputy Alan Kelly: Yes and the second part of that question - what happens when Ms Magahy does not get what she wants? What is she going to do?

Ms Laura Magahy: I cannot anticipate that because I am sure I will get what I want. Being serious, one cannot do something unless one knows one has the right resources behind it. I will not be promising that I can deliver something unless I have the right resources. I will not know I have the right resources for the next number of months. To be fair, until the end of the year, when I have worked out what the priorities are, which I have committed to doing and which I will do, it is hard to predict exactly what they will require. The things the Deputy outlined in terms of bringing the community care closer and making sure it works properly is definitely and the other things he outlined, the home help, diagnostics and so on, are absolutely priorities. If the whole system is going to work, that has to be a first focus.

Deputy Simon Harris: University Hospital Limerick has one of the most acute situations in terms of a lack of bed capacity. The Deputy has highlighted it here many times. They are working very hard at hospital level to develop and deliver on a modular proposal. My understanding is that they sought planning permission and that there may be a further appeal there. That information is subject to correction; I just read it somewhere. Subject to that being rectified, I want to see this progress urgently.

Deputy Alan Kelly: What are the timelines?

Deputy Simon Harris: It depends on the completion of the planning process.

Deputy Alan Kelly: Say that is done in a few months.

Deputy Simon Harris: We will be ready to go as soon as they are ready to go in terms of progressing it. I want to thank the hospital group CEO. She put a lot of work into it and ploughed on with it as well, which was very important for being ready. In Clonmel, the 40-bed modular is progressing. My understanding is that it is due to open very early in the new year. I will confirm that with the Deputy. I hope to be in a position to visit it shortly.

On geo-alignment, what the Deputy said is 100% correct. If the idea of Sláintecare is to reduce bureaucracy, increase accountability and move more services locally where appropriate to do so, we need to have regional entities with joined-up thinking and a continuum of care for the patient. Until we grasp that nettle, we cannot move forward much further. That is why we have taken a decision and there are a number of actions. The first strategic action is to consult and finalise decisions on the geographic alignment of hospital groups and community healthcare organisations by the end of this year. I will announce by the end of this year what I would like to be the regional entities; ultimately, it will be a matter for the Oireachtas to legislate. In 2019, in another specific action, we will introduce modifications to the hospital groups and community health organisations to ensure geographic alignment and will begin to develop processes for integrated performance management on an interim administrative basis. We will let them bed in and test. We will start in 2019 to devolve decision making. We have done this already with the hospital groups. We will devolve decision making and autonomy in line with their functionality. The action plan states that in 2021 we will legislate for these revised structures but, if I am to be very honest, if there was a willingness in the Oireachtas to legislate a little bit earlier I would be very open to doing that as well. I would like to do it quickly.

The other action on the alignment piece is for next year and is a really important one. As well as doing this, it is also envisaged to define the new organisational operation structure in terms of what the new slimmed-down HSE will do over time and what the Department of Health will do over time, the Department in the context of Sláintecare and the HSE in the context of new regional entities. There are five specific actions there on geo-alignment all taking place by the end of next year.

On Dr. Donal de Buitléir's group, publicly he has stated that he will have his work completed by the end of this year. I would hope to receive that report by the end of this year or very early next year. It is going to be a very important piece of work. As the Deputy knows, there are many vested interests arguing as to why we should not do this. There are many people whom the Deputy and I represent who need us to get it right. We need to get it right on a phased basis and in an appropriate way. I will be very much influenced by the work of that expert group which includes a lot of really good expertise.

On the GP contract, put bluntly, yes, I expect to be in a position to see progress if there is willingness on both sides, which I really think there is but it takes two sides to negotiate. I have a mandate now from the Department of Public Expenditure and Reform and from my own Department in terms of policy objectives being aligned with the funding stream.

Deputy Margaret Murphy O'Mahony: I thank the Minister and Ms Magahy for attending. I especially welcome Ms Magahy and wish her well with what will not be an easy task. If there is anything I can do personally, my door will always be open to her. Well done to everybody involved in Sláintecare. Much hard work went into the plan. It is fantastic that health is now above politics and, through Sláintecare, it will remain that way and we will all be on the same hymn sheet. Other Departments should take note and act accordingly.

I apologise if I repeat any of the questions asked by other members. I had to step out to meet some farmers who travelled from west Cork. The Minister said the Sláintecare programme will move the health system to a population-based approach. Will he elaborate on that statement? He stated "new models of care will be designed that are structured, coherent and tailored to population need." When does he expect this to occur? Could it not have been started already?

The Minister also stated the implementation of Sláintecare will require a stronger system of

community care. Has a decision been taken on what that system will be?

The Minister emphasises that Sláintecare will be "for those who need it most". I find that description abstract and I wonder what the criteria will be. Who will decide who needs it most?

This may not be the correct forum but, on a personal level, I ask for the Minister's permission to contact him about a matter. I was contacted this morning by a constituent who has been waiting for 17 weeks for the result of a smear test. An initial test came back unclear so the patient was advised to retest. She has now been told she will have to wait another 17 weeks for the second result. May I contact the Minister on that matter?

Deputy Alan Kelly: This is happening around the country and is becoming a significant issue.

Deputy Simon Harris: I would be happy to discuss that with Deputies Murphy O'Mahony and Kelly.

A population-based approach ensures we design the structures based on where our population is, rather than designing the structures and then hoping the population finds or makes its way to them. We will look at a map of Ireland not just in a geographical sense but in terms of where our citizens live and what needs they have. Ms Magahy spoke passionately about citizen engagement and empowerment. What do the citizens of Deputy Murphy O'Mahony's region or my region want their health service to look like? We need to develop the structures around that, rather than continuing, as we have often done in healthcare, to put up the structures and then tell patients to come and access them.

On why new structures are not yet in place, that is a valid question and one that many people at home are also asking. The Deputy made the point that Sláintecare is above party politics, which is exactly the answer. The risk is that if I, as the current Minister, or another Minister before or after me, tinkers with and starts changing the structures, they then become the structures of this or that Minister and often do not last the test of time. There has been far too much chopping and changing in health, and all of us in the political system are collectively guilty of not allowing the health service to properly bed in to a programme of reform. The beauty of and difference with this programme is that while I, as the incumbent, will implement it, in all likelihood those who come after me will also have signed up to it. This means there is a good chance it will be done and will stand the test of time.

On community care, we have made progress on some of the issues. We have given a commitment, for example, to a statutory home care scheme. I know the Deputy has a strong view that, as politicians, we say we want everyone to be able to grow old at home in his or her own community with dignity but the only statutory scheme we currently have is the fair deal for nursing home care. Home care around the country is variable in its delivery. The idea that there would be a statutory home care scheme is one example of the community care. The model we need to roll out for our nurse practitioners and the general practitioner contract is still ongoing.

What do we mean by "those who need it most"? The authors of Sláintecare, many of whom are here today, are trying to move away from a position where the ability to pay trumps medical need. This is a move with which I agree. We want to ultimately have a system where nobody lies awake in bed at night wondering if he or she has the money to access healthcare the next day.

Deputy Bernard J. Durkan: I welcome the Minister, Ms Magahy and the officials and

wish them well in the task they are undertaking. They need all the luck and assistance in the world. The structures that are now emerging are not exactly my first choice because the question that comes up all the time is whether the HSE is the appropriate structure to evenly deliver throughout the country the services that are required. I still hold that view although I note the implementation group has a minor version of what I had in mind, and hopefully it will work.

The population of the country has increased significantly in the past ten or 12 years, and it will increase more. It is double what it was in the early 1960s and that should be taken into account. If we rely on community care and primary care systems, we need to know whether we have the capacity and capability to do the job that is required at that level. However, we have not yet found out if that is the case because it has not been identified if we have that capacity. We do not know whether we are making the best use of the available resources, such as theatres, consultants and so on. This will not happen unless services are delivered around the clock. People do not get ill from Monday to Friday only. The problem is serious and unless we do something about this issue, it will worsen.

I am glad to see the bed shortage issue is being addressed. Various people have stated repeatedly before different committees of which I have been a member, including this one, that we have too many beds. We still hear this argument from time to time. I am glad it has finally been recognised that we need to have sufficient beds and accommodation and we need to ensure patients are not parked on trolleys around corridors, which creates a health and safety issue for patients, staff and everyone else. We also need to compare our costs and expenditure with those of other OECD countries. There is no use spending more on average than everyone else while delivering less. We must deliver on a par with our competitors. Otherwise, we have a problem.

There are specific areas where treatment has been lacking in recent times. Scoliosis is one case in point. I cannot understand how it took a survey by RTÉ to identify the extent of the problem and its most acute aspects. That should not happen. If the system had been vigilant, internally capable and doing the job it is supposed to do, we should have seen the problem long before we reached that stage. We need to be able to deliver services in a much sharper fashion for children and other patients on waiting lists who have acute problems. There are countries that do that with fewer facilities than we have. Will the Chair please tell me when I my time is up?

Chairman: The Deputy has three and a half minutes remaining.

Deputy Bernard J. Durkan: We are not doing so bad.

Chairman: We need to get answers from the Minister though.

Deputy Bernard J. Durkan: We will get them all right. I have raised the issue of primary care centres before. I am not certain they are capable of delivering the quality, level and extent of community care that are required. I do not know as I have not yet seen them do so. In some of the primary care centres there is not equal participation from the public sector nor equal access. That is not much good to us if we are trying to deliver a service to the general public. That is enough for the moment. I said I would pull the handbrake a bit earlier.

Deputy Simon Harris: I thank Deputy Durkan for affording me the time to reply within the seven minutes. I do not disagree with the Deputy at all that the current construct of the HSE is not fit for purpose. That is not just my view but it is the view of the HSE. The former director general of the HSE said that at this committee, calling it an "amorphous blob", as reported

in the national media. The HSE, as constructed, is not fit for purpose.

There is a need for a national entity, and this is echoed in Sláintecare. There are many good things in our health service that would not be achieved without a national entity, including the national maternity strategy, the national cancer strategy and potentially procurement and human resource elements. These are issues where it makes sense for them to remain in the national core, although that core is far too big and bloated. The idea is to devolve as much as possible to the regional entities, with those entities having a board and being accountable. Although it is not a criticism of people and I can find myself in the same position, all too often people in the Oireachtas raise questions because they cannot get answers at a local or regional level. Affording people the chance to access information about their own healthcare in a local or regional setting makes sense.

The Deputy is entirely correct to raise the idea of population increases as everyone speaks about the health service as though it is static. I am thankful we have a growing and ageing population. People are living much longer in Ireland and we want them to be able to live good, healthy lives, with a good quality of life. I should be clear that the mantra that there are too many beds in the Irish health service is gone, over and dead. We have far too few acute hospital beds and it is highly regrettable that we went through an era of people deciding we had too many beds. It was not an economic argument but rather an ideological argument. They believed everything could be done in primary care. Much more can be done in primary care but we have the evidence with the bed capacity review that many more acute hospital beds are required. The person who needs an intensive care unit bed will never be seen in primary care so increased acute capacity is required with the primary care element.

The Deputy is right to ask the question about primary care centres. They have the capacity to do much more. I will give the example of the one I visited and opened in Castlebar, where there is now an X-ray facility. Under the governance of the hospital in Mayo, as Senator Swanick knows well, there was a position where many people had to go to the general hospital and there was a waiting list for X-rays. The operation of the X-ray facility I mentioned has effectively eliminated the waiting list for X-rays. We have all these fine buildings and there is much good work going on in them. I do not mean to in any way downplay that. There is an ability to do much more. Deputy Donnelly and I represent a constituency with a primary care centre in Carnew and before it was in place, people from Carnew and south Wicklow were travelling to the Mater hospital for wound management. That can now be done locally. There is a definite ability to do much more in primary care, and that is what Sláintecare is about. It is also what our capital plan is about in the form of putting diagnostic infrastructure in place.

Senator Keith Swanick: I thank the Minister for coming along and I congratulate Ms Magahy on her new role. I will speak initially about primary care. I welcome the Minister's comments on the funding of primary care, particularly multi-annual funding. Does the Minister see any possible rowing back on the financial emergency measures in the public interest, FEMPI, cuts applied to general practice? I agree with Deputy Durkan and I welcomed the primary care infrastructure plan, which produced more primary care centres around the country. However, I have said on multiple occasions that it is not necessarily about bricks and mortar but rather the activity that happens within the primary care setting.

Deputy Simon Harris: Yes.

Senator Keith Swanick: With a small amount of funding, much progress could be made on a day-to-day basis providing higher quality of care to patients. That is basically what it is all

about. As we know, general practitioners on a daily basis often carry out nursing duties. Many of my GP colleagues around the country would agree with me in saying that even a small 10% refund of the FEMPI cuts could facilitate the sending of staff on training for nurse prescribing, for example. Too much emphasis has been placed on the provision of primary care centres around the country when it is the provision of care that is important. Does the Minister agree that any possible unwinding of the FEMPI cuts in the general practice sector should be kept separate from contract negotiations? Will that process occur in an aligned fashion?

We speak of marrying primary and community care, as well as providing more new beds in the hospital sector, which I agree with. The Minister mentioned the HSE's indication that there is capacity to provide 600 new beds between modular units and reconfiguration of existing wards, etc. There is a major under-utilised resource, which I have spoken about on numerous occasions, which is the community hospital sector across the country. Is there a specific fund within the implementation strategy for the community hospital sector, in particular? The Minister mentioned the X-ray department installed in the new primary care centre in Castlebar but there are four district and community hospitals in the Mayo region. There is an X-ray department in Belmullet hospital used once or twice per week, and there is an X-ray department in Ballina hospital. Community hospitals should not be seen as a relic of a bygone era. There is a major resource of beds not being used and they should not be seen as glorified nursing homes. They help facilitate discharges from hospital and they prevent admissions to acute hospitals. There is no reason somebody who has a hip replacement done at Mayo general hospital could not be rehabilitated in Belmullet, Castlebar or Swinford a couple of days later, for example.

We need to specifically consider the redevelopment of our community hospital sector as a way of taking pressure off the acute sector and opening access to GPs to admit to the community hospital sectors directly. For example, people could be admitted and have a medication review, a chest X-ray or some blood work done. An elderly person might have a brief admission for one week, and that would prevent an admission to the acute hospital sector. It would save much money. It is something that should be examined as it may have been overlooked in the Sláintecare report. What are the Minister's thoughts on that?

Deputy Simon Harris: I agree that bricks and mortar cannot be, and is not, all there is to primary care. The buildings can be enablers for change, integrated care and multidisciplinary working. I opened one in Grangegorman only a few weeks ago and, as the Senator knows, it brought together many healthcare professionals who for the first time were working together under one roof, providing integrated care for a patient. That is the benefit I see in the bricks and mortar aspect but it is not the end of the conversation. It is what happens within those buildings that is really important.

I do not want to negotiate with GPs through this committee and they never like that. Nevertheless I make the point that there are three elements to any discussion we must have. There is an element about sustainability. The Senator referred to FEMPI. I am talking about sustainability but we are both speaking about recognising the fact that GPs in many cases today feel they are in need of supports to keep their current practice and services sustainable. We need to talk about that. I hope the Senator notices I am separating this and making it a distinct point from new services. We need to talk about sustainability of our existing general practice service.

The second point we need to discuss is crucial and I referenced it in my opening statement. It is throughout both the committee's Sláintecare document and my implementation plan. This is chronic disease management. If sustainability is one leg of discussion, chronic disease management is another. What can general practice do in chronic disease management if those GPs

are resourced to do it? I know from my conversations with GPs that there is a willingness and desire to do more but they must be resourced to do it. The third leg of the stool is a conversation around access to primary care and how to advance the Sláintecare ambition as it relates to access.

The three elements are sustainability, Sláintecare chronic disease management and Sláintecare access. They are the three legs of a stool about which we, as a State, need to have a very serious conversation with general practice. The State must be able to come to that conversation with significant resources. I am now in a position to do that. We need GPs to come to the table with a willingness to engage, which I believe is there. I hope that re-engagement will shortly commence.

I agree with the Senator on smaller hospitals. We are underutilising our smaller hospital network. It is important that we provide the right care in the right place, which Senator Swanick, as a doctor, knows better than I do. Smaller hospitals have the capacity to do more, whether in terms of diagnostics, elective procedures or otherwise. I refer to the reopening of the cataract theatre in Nenagh hospital, a so-called small hospital, which will serve the people of the mid-west and reduce cataract waiting lists. I visited Kilcreene hospital in Kilkenny, which has sufficient staff to do more hip operations and sought funding to carry out such operations. I am pleased that we were able to facilitate that. Some smaller hospitals have the staff, capacity and eagerness to do more. Part of Sláintecare is to consider how best to utilises all assets and capacity within the public health service. Senator Swanick made a fine point regarding the role of smaller hospitals in that regard.

Senator Keith Swanick: More use could be made of the district hospital network, which includes some very remote hospitals. Services such as pulmonary and cardiac rehabilitation could be carried out at such hospitals, which would mean that patients would not have to travel for an hour or an hour and a half to a main acute hospital. The provision of such services would facilitate the preservation of our district hospital network. With a little lateral, solution-driven thinking, it is very simple to put in place good services that benefit patients at very little cost. I am be happy to work with the Minister to further such measures.

Deputy Simon Harris: I agree with the Senator. Much of the cost relating to many such facilities is in the capital space. I am pleased that our capital budget has increased significantly which will enable us to have those conversations.

Chairman: The reform programme is not being pursued with sufficient urgency. When the Government came into being, it indicated that reform could not be discussed until after the Sláintecare report was delivered. It took six months longer than anticipated to deliver the report, for which the Committee on the Future of Healthcare must take responsibility. The report was published 17 months ago but we are still talking about devising a plan. I am concerned that there is a lack of urgency. We are locked into that system which perpetuates the waiting lists and trolley queues raised by Deputy Donnelly for the next three years. The Minister stated that trolley numbers reduced in September but the trend is upwards year on year. That is a symptom of what is happening in the wider health services. Trolley queues should not be the focus but they are a symptom of what is happening. I am concerned that there is a lack of urgency because demographic change is continuing as our population is aging and requires more healthcare. The older population require the most healthcare. Demographic change will not wait.

On the point made by Senator Swanick regarding the GP negotiations, almost no GP negotiations took place this year. There were two or three meetings, which is nothing. As we

approach the budget, there is a sudden surge of activity, similar to that before last year's budget after which nothing happened. I am concerned that the budget cycle stimulates movement which then peters out for another year. I ask the Minister to address the urgency with which he will approach the Sláintecare programme.

Deputy Simon Harris: The bona fides of the Chairman in regard to healthcare are beyond question. I hear his frustration and know that it is genuine. As I stated, some of the timelines in the Sláintecare report were unworkable. It would be incorrect to contend otherwise. Although I do not wish to end on a sour note, I must point out that the report was produced in May and suggested that an executive director would be appointed by July. That is not how the world works in terms of recruiting highly skilled professionals such as Laura Magahy. One cannot hire such a person within two months. The report suggests that we should extend access to free GP care to 500,000 persons per year. While I do not speak for either of the GPs in the room, I have yet to meet a GP in my constituency or in my role as Minister for Health who believes that that would be sustainable, rather than resulting in very lengthy general practice waiting lists. Although I fully subscribe to the agenda and endpoint of Sláintecare, a relatively substantial amount of work remained to ensure its correct sequencing such that waiting lists in primary care settings are not created. If we accept that general practice is one of the best functioning parts of the health service-----

Chairman: The report stated that eligibility could not be extended without extending the capacity in primary care.

Deputy Simon Harris: It did, but-----

Chairman: The stimulus for that was to expand the capacity in primary care so that eligibility could be extended.

Deputy Simon Harris: That is what the report stated.

Chairman: There was no expectation that free care would be extended to 500,000 people by the current workforce.

Deputy Simon Harris: That is correct. I am not here to be negative and I want to get on with this. However, the timelines were somewhat contradictory in this regard because while the Chairman is correct that the report recommends increasing capacity, it also states that we must ensure that eligibility is extended in a very short period of time. That would not have worked. I want the committee to know that I, my Department, the Sláintecare office and the HSE believe that Sláintecare is the only plan on health reform. We are moving beyond conversations regarding my view of Sláintecare to a point where we have an implementation plan and, better still, by the end of the year will have the action plan which will detail what we are going to do and who is going to do it, which will be of assistance to the committee in its scrutiny and accountability role. We will then publish reports measuring that every six months. There will be nowhere to hide in terms of progressing the reform agenda.

I am particularly keen to pursue geographical alignment. It may not be politically advantageous but it is crucial in terms of providing regional integrated care and singular budgets. I will invest political capital in trying to bring that forward more quickly than was originally envisaged.

The Chairman and I regularly discuss the GP contract. It has taken much too long for it to be put in place. I now have an agreed mandate on multi-annual funding, and we will go at this

hammer and tongs and try to have it agreed.

Chairman: I thank the Minister. I call Deputy Donnelly.

Deputy Stephen S. Donnelly: I wish to return to the issue of waiting lists because I have been reflecting on the Minister's response. Fundamentally, the current waiting lists have nothing to do with Sláintecare. They have grown beyond recognition to levels never seen before in the history of the Republic of Ireland. Does the Minister accept that solving the waiting lists is possible without Sláintecare and doing so is simply a responsibility of the Government? Regardless of whether the Oireachtas published a Sláintecare report and what is progressing in that regard, does the Minister accept that it is his role to bring down those waiting lists, which have reached hellish levels?

On funding, the Sláintecare report and the team from Trinity College Dublin from whom the committee will hear this afternoon state that Sláintecare is predicated on approximate funding growth of 7.5% per year. That amounts to approximately €1.1 billion per year for the implementation of Sláintecare assuming a base of approximately €15 billion. I acknowledge that the budget will be delivered next week and I am not asking the Minister what he is pitching to the Minister for Finance for next year. However, is he seeking to meet a broad funding goal in line with the Sláintecare report and the view of the team from Trinity College Dublin that the approximate cost will be an additional €1.1 billion each year for approximately ten years?

Obviously, the funding overrun for this year which may amount to more than €600 million is very serious. Is it likely to impact on the ability to invest in Sláintecare for next year?

On assets, both in terms of people such as clinicians, doctors, nurses, speech and language therapists and so on and physical assets such as beds, hospitals, primary care centres, diagnostics, etc., when does Minister believe he will be able to present the committee with a year-by-year forecast indicating how many doctors, nurses, paediatric consultants and primary care centres there will be in various parts of the country? When will the Minister be in a position to present a forecast in this regard?

The Minister said earlier that the HSE is not fit for purpose. There is danger in a Minister for Health making that statement and not setting out a definitive plan for a replacement. In the UK, Mr. Andrew Lansley, on his appointment by former Prime Minister Cameron said that one of the first things he was going to do was disband NHS trusts, with no proposals regarding what would replace them. This caused chaos. One of the greatest mistakes of the former Minister for Health, Senator Reilly, was his statement on taking up that Ministry that he was going to get rid of the HSE, with no proposals on what would replace it, and that caused chaos. The Minister, Deputy Harris, said that the HSE is not fit for purpose, which I believe many people would agree with in spite of there being some phenomenal people working therein every day to help people. When does he expect to have a new organisation in place?

Deputy Simon Harris: I accept that we can make progress on waiting lists in advance of Sláintecare, and aside from it. I believe - I am not being pedantic - the policy shift that Sláintecare represents will help improve waiting lists. If we did not have Sláintecare, it would lessen the pace of progress. I think that is a fair comment. For the benefit of those watching the proceedings, I want to be clear that we are not waiting for the delivery of Sláintecare to work every day to try to improve the waiting lists. I do not want to be pedantic because the waiting lists are too long, but many of these waiting lists were never before published. That is a point worth making. For example, in light of the RTE "Prime Time Investigates" programme, we now pub-

lish pre-planned and what are known as TCI waiting lists. As far as I am aware, prior to me becoming Minister, these were never before published. Prior to 2014, outpatient lists were never published. There are still too many people on waiting lists but this needs to be factored in.

As I said at the launch of the implementation plan in Government Buildings, largely speaking, the costs outlined by the TCD team and the committee are correct. However, as I said earlier during my engagement with the Chairman, a significant proportion of the costs is dependent on contractual negotiations, and not only with GPs. We will also need a new consultant contract at some point, and there will be negotiations on the decisions taken by the Government and the Oireachtas on public and private services. As the Deputy will be aware, private health insurance contributes significantly to our public hospitals and this is factored into the figures provided. Some of the costs are capital and others are current. Largely speaking, I am not engaged in a row with the TCD team or with the Sláintecare committee about the figures, but I am making the point that some of the policy decisions that we have yet to make as an Oireachtas will have a bearing on the costs. For example, Sláintecare recommends the removal of private practice from public hospitals but it also recommends that before doing so, we should do a particular piece of work on it and revert to the committee with a roadmap. This represents a big chunk of money in terms of the overall impact on a yearly basis in regard to the health service.

Deputy Stephen S. Donnelly: On that issue, the question was slightly different. The Minister's response is that he is broadly in agreement with the Sláintecare/TCD figures of approximately €1.1 billion. The question was slightly different in that I asked if, notwithstanding any negotiations with the Minister for Finance this year - I appreciate where we are at in the budget cycle - taking a five to ten-year view, that is the approximate funding for which the Minister is making the case in respect of implementation of Sláintecare?

Deputy Simon Harris: I am making the case for the full delivery of Sláintecare over ten years. What a Government or the Oireachtas will be able to deliver in 2019 and 2020 is a variable. It will be dependent on the choices the Deputy's party makes and on the choices and decisions of the Government. I expect that we will have funding allocated to Sláintecare this year that will enable progress. I want Sláintecare implemented in full over the lifetime of the ten-year strategy.

Deputy Stephen S. Donnelly: I thank the Minister.

Deputy Simon Harris: On the funding overrun, the Minister for Finance is a greater authority than me in commenting on these matters, particularly at this time of the cycle. He has made clear that he believes the funding overrun in health, which sadly is not a new phenomenon and is a reflection of the need for Sláintecare and a more efficient accountable transparent model of funding and delivery, will not affect his spending or taxation plans for 2019. I take him at his word in this regard.

Deputy Stephen S. Donnelly: Is it the Minister's understanding is that it should not affect the ability to invest in health care next year?

Deputy Simon Harris: Yes, my understanding is that the health overrun will not affect the Minister of Finance's ability in terms of his spending or tax plans in the health space. On the assets, I will ask Ms Magahy to respond later to that question because she has a body of work to do in mapping out people need and the capital and infrastructural need over the next number of years.

On the comment that the HSE is not fit for purpose, it is reassuring that it is not just me, as Minister for Health, who is saying that. The director general of the HSE also said that. I am happy to echo the Deputy's point that there are many brilliant people working in the health service, such that saying the HSE is not fit for purpose is not a jibe by me or any political at the staff of the HSE and the work they do or endeavour to do but a recognition that the HSE, as currently set up, is not fit for purpose. I want it to be clear that under Sláintecare the HSE will continue in existence but it will be slimmed down in that many of its functions will be devolved to regional entities in line with the strategy. Unlike the UK Minister referenced by Deputy Donnelly, I make my comments in the context of the plan we are discussing. On when I expect to make the changes, by the end of the year I will be in a position to return to this committee or the Dáil to set out what I think, based on the Sláintecare report, the geo-alignment should look like.

In 2019, we will begin to devolve some of those functions on an administrative basis. The implementation plan states that to allow the system to bed down, we should legislate for those changes in 2021, but, as I said in my earlier engagement with Deputy Kelly, I have an open mind and instinctively would like to legislate earlier if there was a majority view in the Oireachtas that we should do that. By the end of this year, what the map of Ireland from a structural point of view will look like will be published. From 2019, we will commence administrative changes and from 2020 to 2021 we will begin legislating in this regard. That is my proposal, which is very much in keeping with Sláintecare.

Deputy Stephen S. Donnelly: I thank the Minister. The question that people in the HSE will ask, as they did when the Minister's predecessor, Senator Reilly, said he was going to get rid of the HSE, and as happened when Mr. Andrew Lansley said he would get rid of the primary care trusts, is, "Will I have a job?" Slimming down means fewer staff, which means some people will be on voluntary or compulsory redundancy unless there is natural attrition. We have a lot of very good people within the HSE. We all agree there are layers of bureaucracy that should not be there in the organisation and, the same applies in some of the acute settings as well. Many good people will watch this process carefully and think their job or post may not exist in the new slimmed down agency. When will people know if they will have a job in the new HSE?

Deputy Simon Harris: We are not there yet. I am sure the Deputy will agree that I could not make announcements in that regard in such a public forum. These are conversations to be had with representative bodies at an appropriate time. This is about where people work. Many of the people working in the HSE today may work in a devolved regional entity into the future. The HSE has employees throughout the country. An analysis will be conducted on the needs of the health service, such that we will not know for two years or more how many staff are needed. The HSE is involved in the implementation of Sláintecare. Sláintecare is the policy direction for the HSE and it is embracing it. We will get this right. When we did big programmes of reform in the past, for example, the abolition of the health boards and the creation of the HSE, this is an area where we did not get it right. That is an objective comment. We have to get it right this time. We have to look at these issues sensitively and carefully. We must not do so in a knee-jerk fashion. We are talking about something that will happen over a number of years. To answer the Deputy's question, it will probably take around two years.

Deputy Stephen S. Donnelly: I thank the Minister.

Deputy Simon Harris: Ms Magahy would like to respond to another question asked by the Deputy.

Ms Laura Magahy: The Deputy asked about the sequencing of decisions in respect of assets. I suppose that is what I will look at between now and the end of the year. I have been tasked with a series of 106 actions and looking at the dependencies between those actions. I am thinking of rolling it out over a number of years using the concept of a citizen care master plan. This will involve looking at population needs on a geolined basis and looking at service design care pathways, before then looking at the infrastructural needs and e-health needs that will be required to support the newly developed service design care pathways and, critically, looking at the resources needed by the teams of the future - what the teams will look like and what the numbers will be. That will take some time to sort out. It will need to be done in an orderly fashion.

Deputy Stephen S. Donnelly: Does Ms Magahy have a sense of when she will be able to report on the projected workforce and physical asset needs?

Ms Laura Magahy: I will have visibility of that by the end of the year.

Deputy Stephen S. Donnelly: Great.

Chairman: I would like to raise an issue before I call Senators Colm Burke and Bernard Durkan.

Deputy Bernard J. Durkan: I do not welcome the demotion.

Chairman: Sorry, I meant Deputy Bernard Durkan. I ask Ms Magahy to outline what a citizen care master plan is.

Ms Laura Magahy: Absolutely. We are not starting from scratch, but we almost have to start from scratch as we determine the ideal way to plan for the projected increase in population from 4.6 million to 5.2 million over the next eight to ten years. We will start by looking at where the various sectors of the population are located, what they look like, what their needs are, what their age profiles are, where they stand on the deprivation index and what their requirements are. Then we will build up a service in respect of that population. It was mentioned earlier that it is better to do it that way rather than setting out where the buildings are and asking the service to respond to that.

Chairman: Does it involve population health?

Ms Laura Magahy: Exactly. That is what the citizen care master plan is. I hope that at the end of this process, we will have something people can relate to. They will be able to say "this is the health system of Ireland". They will be able to look at it and understand how they can interact with it. It is a physical planning exercise, a service planning exercise and a communications planning exercise.

Chairman: When will the citizen care plan be available?

Ms Laura Magahy: It will take time. I will come back at the end of the year to say how long it will take to draw it up. It is not something that we can do in a matter of months.

Chairman: Okay. I thank Ms Magahy. I call Senator Burke.

Senator Colm Burke: I apologise for not being here for part of the meeting. I was dealing with the Minister for Justice and Equality on a Commencement matter in the Seanad. I would like to ask the Minister about Project Ireland 2040 and the Sláintecare report. It has been identi-

fied that additional hospitals are needed in certain locations, including Cork. I understand that a group of people from various agencies in Cork, including Cork City Council, Cork County Council, UCC, the voluntary hospitals and the HSE, has been put together with a view to identifying a site for a new hospital in Cork. The identification of a site is a crucial issue. There have been 25 years of delays in developing a new children's hospital in Dublin. Even though all of the people who should be on this group were identified six or eight months ago, I understand the HSE has made no effort to call the group together. I am a little concerned about that. The first issue is identifying a site. The next issue is going through the planning process. These issues have to be dealt with before budgetary commitments are made. It should be simple to identify the pros, cons and disadvantages of a number of sites. I will explain why I am concerned to ensure this is treated as a priority. The population of Cork city and county has increased from 410,000 to 542,000 or by 130,000 over the past 30 years. It is growing at a phenomenal rate. Within the next eight years, there could well be a population in excess of 700,000 in the area in question. For that reason, I this serious issue is a priority. I would like to know whether the Department of Health can communicate with the HSE on this issue. We are talking about building additional units. At what stage do we start looking at sites? I am a little concerned about that.

I would like to raise a second matter. Over the past three years, the HSE has taken on more than 12,000 additional people. The number of staff in the HSE has increased from over 99,000 to over 110,000. I have concerns about the number of people being taken on in administration and management. I accept fully that they need support. If one looks at the entire staff of the HSE, more than 17,600 people work in administration and management and a further 7,500 are in nurse manager roles. Technically, there are more than 24,500 people in these positions. In fairness, nurse managers also provide nursing services. We seem to have a management structure everywhere. One of the problems I find with the HSE is that I cannot get anyone to make a decision. I recently dealt with a case in which 12 people from the HSE and Acquired Brain Injury Ireland were summoned to a meeting to make a decision on one person. Just 24 hours before the meeting was due to happen, one person announced that he or she had moved to a new job in the HSE and would not attend the meeting but did not set out who would attend in his or her place. As a result, the meeting was cancelled. I find that astonishing. I have come across many cases in which a medical practitioner who is trying to make a decision about a particular patient reports to management the issues he or she is dealing with, only for three different groups of people in administration to tell him or her how he or she should manage the patient in question. This is causing significant morale problems for nursing and other staff in hospitals. It seems that no one can make a decision on a particular issue. I raised this last week when Dr. Holohan came before the committee to speak about the proposed patient safety Bill. Doctors and nurses are being held accountable for every step they take, but we do not have any accountability on the managerial side. I refer not only to the decision-making process on the managerial side, but also to the delays in making decisions. When was the last time a HSE manager was disciplined? It is right that doctors and nurses are held accountable when errors are made. I wonder what process we can set up to deal with this issue if we want to have reform. There is resistance to reform. How do we propose to deal with this issue in that context?

I would like to mention a final issue. We met Professor John Higgins from Cork last week to discuss gynaecological services. A second theatre needs to be opened in Cork to deal with such services. The HSE ended up renting space from the Mater Private Hospital in Cork and the consultants moved to that hospital. Public patients were dealt with there in an organised way. More than 1,500 people were taken off the waiting list as a result of an initiative led by management and consultants. It seems that problems have been encountered in opening the second theatre in Cork University Hospital so that this service can be provided. We have the space and the

theatre, but we seem to have a problem getting it opened. If we want to implement Sláintecare, how do we deal with all of the issues that will arise? We are trying to get people to accept that change must come about, that they must take responsibility for the decisions they are making and that they must take the people around them into account.

Deputy Simon Harris: I will respond briefly to the three matters raised by the Senator. I fully agree with him that the hospital in Cork needs increased capacity, There is a particular need for acute hospital space. As the Deputy has rightly said, the population has grown significantly, but the bed base has not. That is why we announced an acute hospital development for Cork in the capital plan. We also said that Cork would receive one of three elective-only hospitals, to which I referred earlier in the context of the Scottish model following my trip to Scotland last week. I take the point the Senator makes about the next steps in these capital projects and ensuring that, when capital funding becomes available, we will be ready to go in having the sites available and planning permission obtained in order that we will be able to go to tender. In the next few weeks I will convene the relevant stakeholders in Cork to seek an action plan on the next steps to be taken. I will keep the Senator, as well as other Oireachtas Members from Cork, informed and updated, as necessary.

Making sure we have clear management structures in place at regional level is at the core of Sláintecare. They have been lacking to date, but we will have geoalignment and one integrated structure for the community and hospitals in order that people will not get stuck in one part of the health service. There will also be a regional board in order that we will be able to look at decision makers in the eye and demand that they account for their actions.

I am pleased that we have increased investment in Cork University Hospital. We have also supported clinical autonomy in the budgetary process. The hospital has made great progress in dealing with gynaecology waiting lists. I thank Professor John Higgins and the clinical team for the work they have done in that regard. I am keen to see if we can do more to support their good work in the context of the budget. I will be happy to discuss the matter further with the Senator.

Chairman: The Trinity College Dublin team will be coming in soon and I want to give it an equal opportunity to discuss the Sláintecare implementation strategy. If Deputies Louise O'Reilly and Bernard J. Durkan combine their questions, we can allow the Minister to leave.

Deputy Bernard J. Durkan: There is a notion that the issue of waiting lists has only arisen in recent times. That is not true. I remember dealing with cases in my constituency in 2001, 2002, 2003 and 2004, when people had been waiting for up to seven years for a hip replacement operation. I remember one case in which somebody had been waiting for nine years. They were in extreme pain and had repeatedly tried to gain access to the service. Whatever blocked it at the time did so seriously for persons who were in acute pain. Some people were unable to access the service before they died and they died in pain, which was a terrible reflection on the system at the time. This, therefore, did not start in the last couple of months.

I disagree with Deputy Stephen S. Donnelly on the abolition of the HSE. The Minister's predecessor was right, but he did not press ahead with the next phase to replace it with the structures required. I pointed this out at the time. The HSE was the wrong structure and the decision to replace the health board system was the wrong one. However, it was based on expert opinion from the United Kingdom, based specifically on the situation in the greater Manchester area which had the same population as Ireland. Some of us pointed out that it could not be done in the same fashion because the two were chalk and cheese. One was a vast geographical

area, while the other was a compact urban area that was ideal for the delivery of concentrated services in the shortest possible time. The sooner we recognise that we are dealing with a very different system from the one in the greater Manchester area, the sooner we will move forward.

In the control centres of big transport operations worldwide operatives have big screens in front of them on which they can see the movement of traffic. Whenever there is a stoppage they know instantly what to do. The same should apply to the health service, although obviously in a different format. We need to identify the snags which slow the system, thus denying a patient access to it. The HSE should not be regarded as an employment agency but as a vehicle with which to deliver services to patient, the needs of whom are paramount. If we do not realise this, all the talk, re-evaluation and restructuring will come to naught. When there are snags, as with traffic, they cause problems to back up and they get worse and worse. What action can be takem to deal with this issue? Can we focus on it? We could carry out an audit of the weaknesses in the system, but if it does not work for even some of the time, we will not deliver anything. The sooner we recognise this the better. We can play around with it all we want and blame one another for it, but we need to develop a smooth, free-flowing system that will keep patients moving in a circular movement to have them dealt with quickly. What provisions does the Minister have in mind to identify the snags for individual patients and take action to deal with them?

My last point is about overruns. There have been overruns in the health service for the past 20 years. Which disciplines are the most seriously affected and which are guilty of having overruns every year?

Deputy Louise O'Reilly: Deputy Bernard J. Durkan is right that overruns are not new in the health service. Denying that there are overruns is new, as is pretending that they are not recurring. I can play the game of which previous Government made the biggest mess of the health service, but it will not profit us much. I asked the Minister how the overruns were related to recurring costs. There is a difference between recurring and once-off costs. A once-off cost can be incurred to deal with an event that places unprecedented pressure on the health service. I am not referring to the flu but other unforeseen events. Mr. Tony O'Brien wrote to the Minister earlier this year about the issue of recurring overruns. Does the Minister accept that there are overruns and is it his intention to deal with them? I am not asking him to divulge the fourth secret of Fatima, about which we read a lot in the newspapers.

Deputy Simon Harris: It is as good as any other way of getting it.

Deputy Louise O'Reilly: Was Mr. O'Brien right? Were his figures correct? Were they exactly right or roughly correct? Are the actual figures worse? Is it the Minister's position that there are recurring overspends and that there is not a single incident which places unprecedented pressure on the health service?

Deputy Bernard J. Durkan was also right to say patients had to be at the centre of health services, but there will be no health service without staff to work in it. There will just be big empty buildings with a lot of sick patients in them. We need some strategy to deal with the issue of recruitment. We might disagree on whether the Minister's strategy is failing, entirely or in part, but staff will be required to implement Sláintecare. Nurses are engaged in consultations and have signalled that this issue may lead to industrial action. I understand doctors and consultants are more or less in the same space. The health service is haemorrhaging staff and potential industrial relations difficulties are mounting up. This makes the service a very unattractive place in which to work. In some respects, the purpose of Sláintecare is to ensure those who are graduating and bright health professionals working within the system, as well as all other staff

who keep it going, will see that there is a plan and that in time the HSE and the health service will be an attractive place in which to work. There was a very unfortunate incident where the number of student nurses increased overnight from 435 to 870. They had been counted as 0.5 equivalents and then they were counted as a whole-time equivalents. That does not add a single extra person but it makes the figures look good. It does not add a single extra body to a ward. We do not need any more of that but we do need honesty regarding where the recruitment challenges lie and about a detailed plan to be put in place.

The Dáil supported a Sinn Féin motion on nursing recruitment and retention and it was very clear in saying that pay has to be at the heart of it. We spoke to Kevin Duffy, the chair of the Public Service Pay Commission last week at another committee, and he said he was explicitly told not to focus on pay and that it was not a pay review. We can all pretend that pay is not an issue but we are ignoring the nurses, doctors and allied health professionals who tell us that pay is definitely an issue, not simply in the health service but also in the section 39 agencies and other sectors. I understand there was some progress in that regard. I do not wish to put Ms Magahy on the spot, particularly as she has only been in the job for 22 days, but I would be keen to hear if she has any thoughts on how she is going to be able to crack this nut because no plan will work without the staff to implement it.

Deputy Simon Harris: I agree with much of what Deputy Durkan stated. One of the things we are lacking in the health service is data. I think that is the reason the Sláintecare committee put such a focus on ehealth. I am pleased that we are going to be able to deliver the ehealth agenda in full because of the ability it provides in tracking that to which Deputy Durkan referred in terms of where the blockage lies. If one has a clinical director in a hospital who realises there is congestion in the emergency department, he or she should be able to check on the needs of the patients and say, whether, for example, there are 20 people in beds who need MRI or CAT scans and that if they get those scans, 20 beds will be freed up. The inability to have all the data collated is a blockage in the system and the ehealth agenda is very important in that regard.

I very much welcome the agreement that has been reached at the Workplace Relations Commission in respect of section 39 organisations. I hope it will bring stability and certainty to the staff working in the sector and to those for whom they care and provide services. That is something we welcome. I thank SIPTU, led by Paul Bell and others, for their further engagement.

On the overrun or overspend, I will provide some figures. The Estimates for 2018 provided for gross expenditure of €15.332 billion for health services. Of that, €14.839 billion is for current expenditure and €493 million is for capital expenditure. The last available position at the end of June shows that the HSE's income and expenditure position is €341.7 million above profile. While there are offsetting surpluses and deficits, to respond to Deputy Durkan's question, a large proportion of the overall deficit is in the acute hospitals division. As regards the exact figures in Tony O'Brien's letter or anybody else's commentary, we do know yet because the year is not yet over. I have said on a number of occasions that there will be an overspend or an overrun, whichever way one wishes to classify it, and that will need to be addressed. The Minister for Public Expenditure and Reform and I are seeking to address it and I hope the matter can be resolved in the coming days.

When the HSE publishes a service plan, there is a legal requirement under the legislation for it to say that it is going to deliver said plan within budget. It knows the funding available at that stage. While I accept the point made, it is easily conflated with a failure to deliver everything within a service plan. In fairness, Deputy Durkan is not doing that. People have legally signed

up to deliver the service plan with the knowledge of the funding they have available.

I will ask Ms Magahy to comment on Sláintecare, staffing and how she intends to proceed. She replied to Deputy Donnelly on the issue. I respect the processes being undertaken by the INMO and the PNA and I do not want to say anything to interfere with their consultation with their members. It is important that the process runs its course before I make further comment, other than to make one point. In terms of recruitment and retention, there is a retention challenge in particular for nurses and that is what the Public Service Pay Commission found. We are putting forward proposals in line with what the Public Service Pay Commission said to try to address the challenges. The new entrant pay agreement will ensure the pay of new, often younger nurses restored to an equivalent level to that of their colleagues. That should be welcomed by nurses, teachers and other sectors. I am pleased agreement has been reached in that regard. We also want to see somebody be able to become a senior nurse quicker than is currently the case. There is a financial benefit to that, and also to the specialist qualification allowance. I will not interfere in the process but nurses will have to make an adjudication on those proposals. The executive made comments on that in the aftermath of the EGM but that needs to go through a process and then we need to engage.

Mr. Duffy, of the Public Service Pay Commission, does also say in his document that there may also be at some point in time, which he does not specify, where there should be further engagement. He specifically references Sláintecare because, as the Deputy correctly indicated, the delivery of Sláintecare will require healthcare professionals, including nurses, and may also require people to take on different roles and tasks and to work in different structures. I am conscious that the line is there in the report of the Public Service Pay Commission and I am eager to explore it further but I am respectful of the process.

Deputy Louise O'Reilly: Mr. Duffy has acknowledged that there should be further engagement at some point . That is grand, but does the Minister not accept that the time might be now? The recruitment and retention crisis is happening now. We are discussing things that we say are new but that are not such as, for example, waiting lists. Perhaps the position is worse now, perhaps it is not - I do not know. I represented nurses for years and we did not have challenges with recruitment and retention.

Deputy Simon Harris: I accept that. I stated that in the Dáil and at the IMO conference and I say it here because it is the truth. We have an issue with the retention of healthcare professionals. One could argue the toss about recruitment because the stats show that people sign up to be nurses and doctors but the length of time people stay in the health service is a cause of concern.

Mr. Duffy and the Public Service Pay Commission have made some more general comments, including the one I referenced on Sláintecare, but it also made specific commitments we want to extend to nurses such as the qualification allowance and the senior nurse's scale, and coupled with that is the position regarding new entrants. I would like nurses to consider that in the context of their discussions and following the outcome of the discussions I look forward to engaging with them.

Chairman: I thank Ms Magahy and the Minister for attending in order to discuss the Sláintecare implementation strategy. I am sure we will meet them again in the medium term. We will suspend briefly to allow the next group of witnesses to take their seats.

Sitting suspended at 11.50 a.m. and resumed at 12 noon.

Chairman: We are back in public session. In this session we are meeting with representatives from the Centre for Health Policy and Management at Trinity College Dublin to get their views on the Sláintecare implementation strategy. I welcome Dr. Sara Burke, Professor Steve Thomas and Dr. Bridget Johnston. I wish to draw the attention of the 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 this committee. However, if they are directed by the committee to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise nor make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Any opening statements made to the committee will be published on our website after the meeting. Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

I invite Professor Thomas to make his opening statement.

Professor Steve Thomas: I thank the committee for the invitation to this meeting. We are delighted to be here. I am accompanied by Pathways team members Dr. Sara Burke and Dr. Bridget Johnston, whose assistance has been invaluable.

The committee asked us to evaluate the Sláintecare implementation strategy and present our work on re-phasing the original Sláintecare costings. This research was presented at the final seminar of the pathways to universal healthcare project, funded by the Health Research Board, HRB, which took place a week ago in Trinity College. It also draws on our experience of working with the Oireachtas Committee on the Future of Healthcare at the end of 2016 and early in 2017, when we had the privilege of working closely with some members of this committee.

The Sláintecare implementation strategy was published on 8 August 2018 and Ms Laura Magahy began as the executive director of the Sláintecare programme office in September 2018. The implementation strategy has four goals and ten interlocking high-level strategic actions, each of which have further specific actions. A brief critique of the Sláintecare implementation strategy follows, using the framework which structured the work of the Oireachtas Sláintecare report. We compare the treatment of vision, principles, entitlements, integrated care, funding and implementation in the Sláintecare implementation strategy with the Oireachtas Sláintecare report.

The Sláintecare implementation strategy refers regularly to the Sláintecare vision and restates the principles contained in the original report. The Sláintecare vision as specified in the Oireachtas report was for a universal health system accessible to all on the basis of need which is free at the point of delivery or at the lowest possible cost. The Oireachtas Sláintecare report defines what it means by universal healthcare and outlines the services that were to be included in the universal system. It specified that all residents would be entitled to these services and that this entitlement would be backed by legislation alongside a wait time guarantee. Everyone in Ireland would be entitled to a full package of services, free or at low cost, within a set period of time. It detailed the phasing and costings required to deliver such care. The Sláintecare implementation strategy is much more conservative, referring to eligibility rather than entitlement. Action six refers to expanding eligibility on a phased basis to move towards universal healthcare. It uses the term "universal eligibility" which is, at worst, an oxymoron and at best, only a conditional commitment. It goes on to state that the vision is that all citizens "will have

universal access to healthcare, in both the acute and community settings.". These statements appear contradictory implying either a lack of understanding of the terms or a watering down of the commitment to universalism as laid out in the Oireachtas Sláintecare report.

The Sláintecare implementation strategy upholds the vision of integrated care as specified in the Oireachtas Sláintecare report. In particular, an imminent decision on the alignment of community services with hospitals groups as well as the allocation of resources through regional integrated care structures on the basis of population health need are both positive aspects of the implementation strategy.

Goal No. 3 of the Sláintecare implementation strategy is to ensure the health service is financially sustainable. It has a strong emphasis on productivity and achieving value for money. However, there is no recognition of household financial sustainability, little about eliminating or reducing charges and no national health fund as specified in the original report. There is a specific action to "design, establish and resource a multi-annual transition fund with appropriate governance to support the change process". While the capital aspects of the Oireachtas report transition fund are included in the national development plan in terms of community diagnostics, eHealth, primary care centres, new hospital capacity and elective-only hospitals, there is no mention of the funding required to train increased numbers of healthcare professionals for strong primary and community care service as detailed in the Oireachtas Sláintecare report. Neither is there any specification of the additional money required to fund the expansion of entitlements and to support the reform process as specified in the Oireachtas Sláintecare report.

The Pathways team has reworked the Oireachtas Sláintecare cost projections to provide another option for funding. This extends the implementation period to 12 years and elongates some of the phasing of specific components within that. We would be delighted to show members some slides of these after this opening statement.

Goal No. 1 of the Sláintecare implementation strategy is to "deliver improved governance and sustain reform through a focus on implementation". This puts implementation up front and centre, with a map of the Sláintecare implementation structure. However, the implementation strategy critically lacks the specifics of the original Sláintecare Oireachtas report in terms of targets, phasing, timelines, milestones and the budget needed to deliver it. It is important not to reinvent the wheel.

In conclusion, the publication of the Sláintecare implementation strategy, the appointment of Laura Magahy and the establishment of the Sláintecare programme office are all necessary and important developments. The Sláintecare implementation strategy begins to do the important task of weaving together reforms that were happening anyway with the Sláintecare reforms. However, there is a need to keep an eye on the Sláintecare Oireachtas vision and ambition and the essential components of entitlement and funding which are lacking in the implementation strategy. Nevertheless, the strategy progresses the Oireachtas Sláintecare report by integrating clinical and corporate governance. The emphasis on public engagement on health and wellbeing, a workforce engagement plan and the development of a citizen care master plan are welcome additions and may well be critical to triggering the political commitment and leadership that is needed to fund and deliver the vision as laid out in the Oireachtas Sláintecare report.

We look forward to further discussions with the committee on this.

Chairman: I thank Professor Thomas for his opening remarks. Perhaps he could go through the aforementioned slides now.

Professor Steve Thomas: Myself and my colleagues will present a few of the slides that we drew from last week's final workshop on the pathways to universal healthcare project. We have selected slides that we believe will provide a useful focus for the committee.

In terms of the first slide, one of the issues that has come up with Sláintecare is whether it is too expensive to implement. Obviously, a further question is whether it is too expensive not to implement, given the current overruns in the health budget. The original Sláintecare report was focused on a ten year implementation plan. A lot of the activity, particularly around entitlement, expansion and the transition fund was front loaded into the first six years, with a maximum amount of €460 million expansion related to entitlements per year, from year three. In our work we consider what might be the effect of changing some of the assumptions behind that. We keep the basic costings and basic items but shift some of the underlying assumptions and look at a 12 year implementation plan. We do not frontload it into the first six years but spread it out more evenly across the timeframe. We push back the start dates of a couple of items, for instance, the inpatient hospital fee removal to year two and the emergency department fee removal to year 11 from year eight. We stretched some of the phasing, particular around universal primary care, which is now elongated to six years for implementation rather than five years.

With the freeing up of GP care and replacing private income in public hospitals, we looked at both phases and took them back a bit and stretched the phasing to get our house in order for preparing and implementing those policies. We try to change some of the underlying assumptions. It is interesting to then look at what impact that has.

On the bar chart, I show the entitlement expansion cost required for each year on the left hand axis. We are running at approximately €250 million for the first five years. By the end of the 12 years, we still arrive at the figure of 2.8, which is shown by the line chart. On the right axis, members can see the total amount coming to €2.8 billion, so that is consistent with the current entitlement expansion detailed in Sláintecare. That will give members a slight idea of the rephasing.

If one goes to the next slide, one can do a comparison with the original Sláintecare costings, which are in orange, and the revised and rephased Sláintecare costings in blue. Substantially less is required upfront but, at the tail end, there is more investment, so it is more evenly focused.

On the next slide, we can do it for the transition cost because if we have a 12-year period rather than ten years and we are elongating the phasing, or delaying the phasing of some of the components slightly, we can redistribute some of the transitional costs as well. The impact of this is to reduce some of the initial burden on the budget. Interesting work was done by the Nevin Economic Research Institute, NERI, particularly for year one. There may be budget constraints but subsequently there will be enough fiscal space to implement Sláintecare. This way of rephasing may get around some of the initial problems with affordability.

I will ask my colleague Dr. Bridget Johnston to follow on.

Dr. Bridget Johnston: The slide dealing with affordability and sustainability from a financial perspective for the Government asks how affordable is health care for households in the current model and the way we are funding it. Currently about 68% to 70% comes from general taxation and the remainder of funding comes from private health expenditure. That is what households either spend out of pocket at the time they access health care or the reimbursement that comes from private health insurance companies back into the system. They contribute

about an equal pot each, about 15% each.

Some of the work I have done for the pathways project is to look specifically at the affordability of this spending by households. Using the household budget survey provided by the CSO, I have been able to estimate that 14% of households were not able to afford what they were spending on either out of pocket charges or private health insurance premiums in 2009 and 2010. By the year 2015 to 2016, this had grown to 17.3% and that probably should be seen in the context of rising charges throughout multiple budgets, but also the increase in private health insurance premia.

What is interesting to look at on this slide is who is mostly affected by this, what these households look like, and what kinds of protection are they supposed to have from the system so that they do not experience this financial hardship. The top bar for the years 2009 and 2010 shows that the majority are medical card-GP card holders. Those represented by the blue bar are considered double, so they not only have a medical card but also private health insurance. They are meant to be protected by the medical card system as well. We can see they are the overwhelming majority of people who are not financially protected, experience financial hardship, and are pushed further into poverty or into poverty because of their spending on either of these items. We can see this grew substantially by 2015-2016, not only for the proportion of households but the breakdown within. We can see that the safety net that is meant to be provided by the medical card scheme is failing those households. This is the overwhelming majority of those who are experiencing financial hardship. In its current form, this system is not protecting people as well as it should.

Chairman: I thank Dr. Johnston. I will ask the same two questions that I put to the Minister when he appeared before us this morning. First, we had a long discussion in the Sláintecare committee about where the Sláintecare implementation office should sit and it has been placed in the Department of Health. We were strongly of the view that it should be placed in the Department of the Taoiseach. Will the witnesses comment on that? Where does that leave us regarding the political buy-in?

There is no reference to a national health fund in the Sláintecare implementation strategy. A major component of the Sláintecare plan was that there would be a national health fund which would be comprised of earmarked taxes and specific funds. In his reply, the Minister said that the funding for Sláintecare would come through the normal budgetary process. We were quite strong that this would not be sufficient funding to implement Sláintecare. Will the witnesses comment on that?

Dr. Sara Burke: There are two separate issues. One relates to where the implementation offices sits and the second to the political buy-in. I was present for lots of heated discussions privately at the Committee on the Future of Healthcare as to where that implementation office should be.

I was in a minority and favoured it being in the Department of Health, because I believe very strongly that the Department is there to drive the strategic direction of health policy in Ireland. If the Department is not driving Sláintecare, what is it doing? It is positive that the implementation office is under the Department. It is critical that there are structures in place to support that work and political buy-in. The implementation strategy has done a pretty good job on the map of the governance structures for Sláintecare and the high level committee with input from the Secretaries General of the Departments of Public Expenditure and Reform and Taoiseach, which reports to the Cabinet sub-committee, and an independent advisory group are all positive

developments. That is a strength of what has happened since the work of the committee.

The question of political buy-in is a separate issue. It was evident from the Minister's presentation this morning that he is wholeheartedly behind Sláintecare. There is an issue as to how far that political buy-in goes. There are political hearts and minds to be won across the Oireachtas, and not just in government, to support for Sláintecare. The international evidence is clear on this. Unless we have political buy-in from the Taoiseach down, and particularly from the Departments of Finance and Public Expenditure and Reform, with the Minister, Deputy Paschal Donohoe having a key role, then it will be difficult for Sláintecare to happen.

Chairman: I thank Dr. Burke.

Professor Steve Thomas: I will take up the second question on the national health fund. It is difficult and probably without precedent to get the current tax base to deliver sufficient resources for the scale of change required to transition the system and reconfigure it.

There is a strong case for making a one-off investment in reconfiguration. As we have seen, even though elements are included in the capital plan, important elements of the new system relating to primary and social care professionals are still lacking. The danger is that with tax, one will always get squeezed out. We have even seen the overrun issue having an effect so there will be a squeezing out. Yet there is no protection and there is no earmarking. It is difficult to protect the necessary space to do that. There probably needs to be a conversation with the public about the earmarking of particular tax into the fund and allocating from that for reconfiguration and entitlement expansion purposes, otherwise the danger will always be that it gets crowded out. However laudable the ambitions, the danger is that they will get crowded out by the immediate need.

Dr. Sara Burke: I wish to make a brief further comment. We hear a great deal about how Sláintecare needs to be funded within the usual annual budgetary frameworks. That says a lot about the absence of political buy-in because if there was political buy-in at the most senior level people would get that this cannot be done within the annual budgetary process and that it needs not just multi-annual funding, but this additional transition fund to shift the provision of healthcare in Ireland.

Chairman: I thank Dr. Burke very much.

Dr. Sara Burke: You can call me Sara, Michael, if that is allowed in terms of procedures.

Chairman: Of course it is. I call on Deputy Stephen Donnelly to make his contribution. We will go through the same format of back and forth for seven minutes, if that is okay.

Deputy Stephen S. Donnelly: I thank the witnesses for their very considered review. It is worrying. The witnesses have been forthright and have called out the areas about which they have worries. I am going to make one nakedly political point to which I do not expect them to respond, although it is relevant to implementation, and then I have four questions. The political point is that healthcare has been extremely badly managed at a political level over the last few years. A lot of that is down to poor implementation and an inability to get things done on the ground - to open up an intensive care unit bed here and there, as required, to make sure that a surgeon gets hired where needed and so forth. I see that incompetence - and this is my view, I am not transposing it onto the witnesses - rolling into the implementation of Sláintecare and it worries me.

My four questions are as follows. The public does not really care about Sláintecare. It is a reconfiguration strategy and it is very important for the future of healthcare and Fianna Fáil is fully signed up to it, but the public does not care. The public cares about getting access to medical care, be it in their home, their local GP clinic, a primary care centre, an acute setting, a rehabilitation setting or wherever else. There is a danger that, as the focus moves on to this shiny and extremely complex and difficult healthcare transformation, the most important thing, which is getting boys, girls, men and women access to doctors when needed, will slide. Could the witnesses point us to what they believe are the most important implementation aspects they think will increase access or reduce waiting times quickly? That is what the public needs. That is what people are screaming for.

The second question is on universalism. Universal healthcare is defined as the ability to access healthcare without incurring undue financial hardship. Sláintecare is ambiguous on this. It talks about universalism, which does not necessarily mean free, but it also talks about free. It interchanges those a bit. The witnesses have raised serious concerns about universal access. Do their concerns relate both to free access and to universal access as the World Health Organization defines it? In other words, they seem to be saying they are concerned about the future ability of people to access healthcare for free, based on what they have seen about people's ability to access healthcare without incurring undue financial healthcare would the witnesses be concerned regardless of which definition of universal is used?

My third question is not really covered in the witnesses' assessment but I imagine they will have a view on it. I have worked on healthcare reform abroad and the single most important thing for healthcare reform to work, assuming one is travelling in broadly the right direction, is the buy-in of doctors. It is the single most important thing. If doctors, particularly senior clinicians, do not buy in, healthcare reform tends to fail. The doctors and their unions are pretty scathing about Sláintecare. These are public statements they have made. I am sure there are individual doctors who buy into it but at an organisational level they have been heavily resistant to Sláintecare, which is something that has to be addressed. Do the witnesses have any thoughts, reflections or advice for us as an Oireachtas with regard to trying to achieve buy-in for Sláintecare and for this implementation at a senior clinical level?

The final question I have is on the costings. I thank the witnesses for the ones they have done. As I read the slides, they have done two - the costs of expanding entitlements and the costs of the transition. Both get to about €3 billion or thereabouts. Have they done an analysis on the total cost, that is, the cost including the cost of entitlement, the cost of transition, the cost of scaling up and any other costs? Do they have a total? Getting to Sara's point, that there is either buy-in for this or there is not, if there was buy-in people would be thinking at a very serious level about deploying very serious resources against this. I am not seeing that from the Department of Finance, the Department of the Taoiseach, or the Department of Health. A total figure would be very helpful. How much do we really need to pour into this, either against the original Sláintecare profile or the witnesses' revised one, which is slightly less front-loaded?

Professor Steve Thomas: Which question to choose? Let us start with the last one first. Shortly after we helped with the production of the Sláintecare report we did an overall costing of what it all adds up to together. It comes to the heady total of approximately €19 billion, but that figure is over ten years. That has to be taken in the context of likely public expenditure of approximately €200 billion in that context. If the figure of €19 billion is thrown around it starts to get scary but the fact is, within the context of €200 billion, it is not that big a price ticket, given that we are then engaging with wholesale reform of the system, universalisation and an

expansion of entitlements. The reason we do not present them together in the costings is that they are slightly different things. The first relates to the annual increment in entitlement expansion while the transition fund refers to the actual amount of money spent. It is somewhat of a case of apples and oranges, but it is probably around €19 billion. Again, that has to be put in the context of the overall spend. That would be my comment on that.

Deputy Stephen S. Donnelly: On that, does Professor Thomas have a year-on-year profile of that €19 billion?

Professor Steve Thomas: I could certainly make that available to the committee.

Deputy Stephen S. Donnelly: That would be great.

Dr. Sara Burke: Perhaps I will take the second last question next, which was the point the Deputy made around how important it is to have buy-in from medical professionals. The Deputy spoke specifically about doctors. In fact, that is very much changing now internationally. The literature is around healthcare professionals and clinical leaders who are not necessarily doctors. A really good physiotherapist or occupational therapist can be just as important a clinical leader as a doctor. There is a strong literature around that and they are needed, but there is also very strong literature around how doctors in particular are often the ones to oppose any type of reform. Once one begins to do it, most of them come on board but there is significant work to be done by the implementation office around engaging clinical leadership - not just doctors but all healthcare professionals and clinicians across the system - to get behind this plan. I do not believe that has been done yet and that is why we specified in our opening statement that the aspects in the strategic implementation strategy around public engagement, workforce engagement and, particularly, clinical engagement and around integrating clinical and corporate governance are really key parts that have been missing from the Oireachtas process so far. That really needs to happen.

Most people go into clinical work of some type or other with the intention of looking after and caring for people. Most people in the system find their jobs extremely difficult at the moment. It is really hard. It is like a case of survival of the fittest. Providing the best quality of care is an obstacle course. If it can be demonstrated to the workers providing that care that this is going to be better for the people who use the services, most of them will come on board. That brings me to the Deputy's first question, which was about the most important aspects of implementation for increasing access and reducing waiting times. There are two questions in that. I will deal with increasing access.

One has to begin showing people the difference that it will make in their lives. A significant part of Sláintecare is shifting care outside of hospitals into the communities and much better primary and social care. Everybody, not just people with medical cards, needs to be able to access the services without a long wait time and, critically, without a charge. Whether that is free or low-cost can be determined. Most of the literature supports the no-cost rather than a low-cost element, particularly if one is trying to get people to use it. It can be used as an incentive for people to use primary care services. Suggestions in the original report like universal child care services, early intervention and child health prevention work and universal palliative care are good. If one uses those aspects, one gets buy-in from the population. The Deputy is wrong. I do not think the public knows about Sláintecare. However, if one talks to people about what they want from their health system, then one can get them on board.

Deputy Stephen S. Donnelly: Which bit I am wrong on?

Dr. Sara Burke: The Deputy said he does not think the public cares about Sláintecare or wants it.

Deputy Stephen S. Donnelly: The point I was making was that nobody knows what Sláintecare is. They are not interested in it. They need the results and access.

Dr. Sara Burke: Exactly. They need to know Sláintecare by experiencing it, whether that is by cutting some of the charges or whether it is free or low-cost. It needs to become a reality for people. The majority of people care about accessing timely and quality health and social care services. One can get them on board for Sláintecare.

Deputy Stephen S. Donnelly: That is exactly the point I was making. The public does not need to be on board for Sláintecare. That is a reconfiguration plan. One needs clinicians, GPs and the HSE. What the public wants is timely and affordable access to high-quality care. I take Dr. Burke's point that it is important to make Sláintecare real to the public by reducing costs. I am asking a slightly different question. The waiting lists have now got so bad that people are dying while on waiting lists waiting to see doctors. That is happening. I am meeting the parents of children who are dying because they cannot get access to surgeons. That is the reality today. In Cork, a child will wait three and a half years to get access to special needs intervention. In St. James's Hospital there is now a six-year wait to see a specialist in urology. It is getting worse.

I take Dr. Burke's point but I do not fully agree with it that one makes Sláintecare real for the public by reducing financial barriers. I believe we have to make it real for people by cutting down these completely unacceptable waiting lists. Does Dr. Burke see specifics in Sláintecare that would quickly begin to address the waiting times?

Professor Steve Thomas: The critical issue is ensuring care is available when people need it. There is a strong commitment in Sláintecare on the wait time guarantees. The evidence is from other countries which brought down their waiting times quite significantly. One needs some kind of mechanism or guarantee whereby people then get an entitlement to care, be it through a strong accountability, as in the NHS, or through vouchers like in Portugal. Unless one has that accountability that there is a guarantee of care, then the system does not shift, no matter how much money one puts into it. System reconfiguration is necessary but not sufficient. One needs that culture of accountability and a culture of much more information availability on waiting times rather than just waiting lists which we do not currently have. One needs accountability to the public on how long waiting times are and much more accountability on the performance of different providers. That needs rebuilding. That is a strong component alongside the system expansion.

Dr. Bridget Johnston: Financial protection is linked in with the access question. We saw the bar chart with the double insurance holders. Essentially, they are covered by the public system by having a medical card but also continue to pay out of pocket for private health insurance. For those who do not, we see a large proportion of that spend, which is not affordable, is to access private care. People cannot wait on the lists. It is not just an issue of making it more affordable and reducing those charges but also ensuring that people feel well looked after in the public system and they are not paying in a way they cannot afford.

Sláintecare is clear that the care is either free at the point delivery or at the lowest possible cost. A number of charges have been introduced over the past several years which bring medical cardholders into the fee-paying fold. We have already designated that these households are not able to afford them. When we look at the comparison over the years, we see that charges

for prescription drugs are driving much of the unaffordable spending for the poorest and most vulnerable households. It is important to ensure the most vulnerable households are not paying for care they cannot afford. That is a significant part of their experience of accessing healthcare. It prevents them from fulfilling their prescriptions and adhering to their medication. It is a serious problem that we need to address.

On the lowest possible cost, Sláintecare does not talk about removing the drug payment threshold but lowering it to a more affordable threshold. There is not this sense of free care everywhere. We are an outlier in the European context in that we do not offer free primary care. People either have basically free GP care or they pay the full cost of it. Even within the GMS, we know patients are paying for signing off on their disability forms and other small charges to primary care providers at the same time. We need to ensure that the safety net is doing what it is meant to do.

Deputy Louise O'Reilly: I thank the witnesses. I am sure when we finished Sláintecare they probably hoped they would never be in this room again but here they are back.

I will make a political point. I do not normally but my colleague has and I will join in. I welcome the Fianna Fáil commitment to Sláintecare. When we launched it, the strongest commitment we got from Fianna Fáil was that it would be brought up at its parliamentary party meeting. The real test of it is what will come out of the confidence and supply negotiations on the budget.

Deputy Stephen S. Donnelly: That is not true. It was entirely endorsed by Fianna Fáil.

Deputy Louise O'Reilly: It was not and we were all in the AV room together. I am not the only person who saw it.

My view is that the legislation comes first. The legislation to entitlements is the driver. Earlier, the Minister appeared to be putting it the other way around. When everything is put in place, then and only then are we going to be in a position to legislate for maximum waiting times and entitlements. That goes against some of what we discussed in the course of our deliberations. What are the witnesses' views on that? My view is that if we keep waiting and we cannot get the legislation until everything is perfect, then everything will never be perfect and we will never get the legislation.

The Irish Congress of Trade Unions, the umbrella body for 90% of the workers in the health services, has a view that Sláintecare will be a key factor in recruitment and retention. It backs Sláintecare as a basis for dealing with the recruitment and retention crisis. Earlier, the Minister and Ms Laura Magahy attended the committee. They did not seem to have anything new to offer in terms of recruitment and retention and how we can attract new staff. To refer to the point made earlier, if we do not get buy-in from healthcare professionals, we will not be able to deliver it. There are steps that can, and should, be taken by the powers-that-be, specifically the Government and Cabinet, that will show us that there is commitment. The public may not understand the intricacies of Sláintecare but they know what a waiting list is. They know when they cannot afford to pay for prescriptions. They know when they are standing in the chemists and have to make a choice between two medications they need but can afford only one. They understand these situations. I am curious as to whether the witnesses have any ideas on what can be done at a high level to instil the confidence that might drive some recruitment and retention. It will not drive all of it but it might drive some level of recruitment and retention. It might also improve the buy-in from those groups where there is not necessarily buy-in. Nurses,

healthcare professionals and doctors via the IMO have substantially bought in. There are issues in Sláintecare that they do not love but they have some buy-in. There is clear hostility from other groups and some of this comes from reform fatigue. Do the witnesses have a view on how this can be driven at a high level to ensure we get buy-in from healthcare professionals?

Professor Steve Thomas: The answer to both questions are the quick wins in the system. These have been deliberately built into Sláintecare, which is one of the nice aspects of it. There are wins we can have without a system change that will just make a difference to people's lives, such as lowering prescription charges, removing hospital inpatient charges and lowering the drug reimbursement threshold per single headed households. These are all overnight wins we can achieve for which we do not need a system response and, therefore, do not need to wait for the system to change.

We do not need to wait for the system to get better before we legislate because there are components we can do now and get into play now. There are components that have a slower build. We need to develop a universal primary and community care setting, which is a key issue. Having quick wins builds trust with the public and investing in the right areas in primary and community care will, hopefully, build trust among providers in the system because they can see where it needs to go, and that we are far too acute focused and we need to have much better non-acute settings. As we talked about earlier, if we put human resources into this setting and make sure we can make good on some of our commitments, people will start to see a system that is changing and that they can buy into, and this is when it will start to build motivation and morale.

Dr. Sara Burke: I agree with the Deputy's first point on putting the cart before the horse and we presented on some of this last week at our seminar. From my read of the strategy, action 6 on "universal eligibility", which is not at term anyone has ever used previously because it is about entitlements, is about reviewing charges and the current eligibility framework, developing a policy proposal and then introducing legislation with no timeline beside it. In fact, Sláintecare outlines clear timelines on legislation, phasing and introduction. It is a step back in commitment rather than a step forward but it was good to hear the Minister speak about entitlements this morning.

With regard to action 9 on the workforce, there are certain "Sir Humphrey" sections in the implementation strategy, in that they go on and on but do not give up too many specifics on how to move them forward. Perhaps this is where politicians can come into it to firm up some of these actions to have better commitment in them.

Deputy Bernard J. Durkan: I welcome our guests and thank them for their presentations. Reference has been made to training an increased number of professionals. We all agree on this. The degree to which this can be achieved in the short term, particularly with regard to retention, is something on which we are not so readily agreed because we do not know how to do it. It has not been shown to us yet. We are competing on the world market for health professionals and the question that arises immediately is an economic one, which is whether we can afford to compete at the level required to attract the appropriate number of professionals into the system.

I remind people that during the Sláintecare committee sittings, I was at pains to point out the battle that goes on in each Department for resources at budget time. There will always be suspicion among other Departments if one Department is given priority. The good part of this is the Department of the Taoiseach is involved, which will give an overview to everybody involved and recognition that there are pressing issues in this particular area that need to be dealt with.

There are equally pressing issues in other areas, such as education and housing. These three areas are fighting for the same resources. To what extent is it feasible to marry together these three Departments in such a way as they can coexist in a complementary way? In particular, elements of housing are complementary to health services in numerous ways. There is the cost and affordability of housing for health professionals and the cost and affordability of housing for patients.

Cost versus vision and entitlement has rightly been referred to. To what extent do the witnesses see progress being made towards achieving the vision and, at the same time, balancing this with the availability of resources that become available? We must also keep in mind that, despite the fact considerable strides have been made in turning the economy around, with the public, Government and politicians in general making a major contribution to this at great cost to the public, we still have considerable national debt, and the servicing of this is also considerable at approximately €6 billion per annum. This must also be brought into the equation. Is it feasible to weave a path between all these competing issues in a way that will achieve the results we desire under Sláintecare?

Professor Steve Thomas: There is no pressure in the Deputy's question. I take on his comments on training. It takes time. Human resources are always the slowest to build and they are the most essential ingredient of any health system to work well. We know we are deficient, particularly in primary and community care where we did not do so well during the austerity years. We lost more professionals from that area than any other. We have recovered less well also, whereby there has been more recovery in human resources in acute settings. Human resources are important and the measures on this in Sláintecare are deliberately phased, particularly if we look at some of the elongated phases. They give us a little more time. I agree we have to think about what motivates people and what will help to recruit and retain people. The international literature shows strongly this is down to quite a broad package of various elements. Salary is one but it is rarely enough by itself. We need to look at training possibilities, hospital environments and good management. A broad package of various elements help people to become satisfied. We need to pay attention to this. While we have managed to import our way out of some human resource challenges, we have lost people who moved on because when it came down to it, the terms and conditions did not work out or there were not enough training opportunities. People felt they were in dead-end positions. It is clear that is an issue that needs to be examined carefully because that is our key investment.

I welcome the creation of additional capacity in the Department of Health and the Health Service Executive to examine all the issues around workforce planning. We need to consider very carefully how we motivate and retain people, which is not just a matter of salary. Does anyone want to take the second question? It is a poisoned chalice.

Dr. Sara Burke: The second question, from Deputy Durkan, was on the progress made on the costs versus the vision. We are only at the starting line, even though the Deputy began that discussion on the committee in June 2016. In a way, the appointment of Laura Magahy and the setting up of the Sláintecare implementation office is the starting line. We have been slow to get here, but we have got here. In terms of costs versus vision, Professor Thomas's slide presentation shows that it is doable but it will require more money. However, there has to be political will to fund and make it happen.

Professor Steve Thomas: The point of doing the revised costings is to take account of the realities of the fiscal space and the important demands and needs in some of the other sectors. What we are saying is that we can still keep hold of the vision, and the integrity of that, but

perhaps phase it in a slightly different way that makes it more realistic within budgetary constraints.

Deputy Bernard J. Durkan: I have an issue with waiting lists. Everything becomes a waiting list in this country and everywhere else as far as I can see. The point about waiting lists is that if it is possible to deal with an issue on the first, second or even the 20th day, it avoids a waiting list building up, be it for housing, health services or something else. There is a already a long waiting list for services and we have to deal with that somehow. If we are waiting to deal with an existing long waiting list and, at the same time, trying to put in place the structures we all recognise are envisaged, how will that work out? Have we paid sufficient attention to those long waiting lists? I am aware the National Treatment Purchase Fund has dealt with some of the cases. When will we get to a stage where the waiting lists are manageable, that is, where people wait for perhaps two months? Will it take four, ten, 12 or 20 years? We need to deal with the amorphous mass and the disappointment and severe pain experienced by patients. I have tabled Dáil questions over the years seeking information on behalf of constituents, for example, elderly people who are waiting in severe pain for a hip replacement or other procedure. The replies state it will take X number of years for the person to be seen. Members often get such replies when trying to deal with the provision of vital services. This seems to affect this country more than any other. We must start somewhere by intervening and saying this will be the position from now on and we will hold the line, while at the same time dealing with the long queue at the other side of that line and ensuring it does not build up again.

Professor Steve Thomas: The Deputy says the problem is bad in other countries too, but that is probably not the case. Ireland is well out of line with international practice, certainly with international best practice. We have some of the longest waiting times in Europe.

Deputy Bernard J. Durkan: Why is that the case when our spending on health is much higher than the average among OECD countries?

Professor Steve Thomas: That is an interesting debate. I am not sure we spend the money well in some cases. We also push back some expenditures onto the private sector. There are incentive structures. We often have a significant amount of dual practice, which can create problems through the different incentives.

I want to come back to the issue of how we manage this problem because we do not have very good information on waiting times. While we have data on waiting lists, we do not have very good waiting time data. If we get much more detailed information on waiting times for various procedures in different parts of the country and make that publicly available, politicians can be empowered to start doing something about it. It is much more difficult to do something to identify the problem when it is hidden behind bad data. What Sláintecare does is provide important investment in ehealth and some of these data systems. Once the truth starts to come out, it will be much easier to manage it better.

Dr. Sara Burke: We discussed this previously in the committee. Dr. Sarah Barry, our colleague, spoke about the spinning wheels. We have address both issues. We have to bring down waiting times, which are unacceptable and inhumane, but we also have to reform the system to ensure we are addressing the people waiting a long time. We must start having diagnostics in the community, including providing same day access to general practitioners for tests, quicker elective care and many more services outside hospital. Once we get that process moving, it can stop the build-up that is happening now. It is not an either-or situation. We have to do both.

Dr. Bridget Johnston: Sláintecare is very clear about this model of integrated care and moving care away from the places of highest complexity into the most appropriate setting for people's care. There has to be a shift away from lists of people waiting to see somebody in a hospital outpatient clinic to being able to meet needs in the community more often. We are seeing significant demand that we are not able to measure appropriately because we do not have the full numbers on individuals. Some of those who are waiting are on several lists. This demand is often channelled into the wrong streams or pots and belong in other places. We need both the resources to get people into the right places in order that we can meet capacity, while also thinking about how we can make the current system better to ensure it will operate much more efficiently than at present.

Chairman: I thank Dr. Johnston.

Senator Colm Burke: I thank the witnesses for their presentations. I apologise for being late but I had an earlier commitment. On efficiencies in the HSE and health service, the witnesses referred to medication and access to GPs. To take the simple example of the cost of drugs and pharmaceuticals, people have access to drugs and pharmaceuticals but do not necessarily use them. On generic drugs, the changes we have brought about in this area have not delivered significant savings.

We talk about pouring money into the health service without examining areas where we can create efficiencies. The witnesses spoke about free access to GPs. Since free GP care was introduced for children aged under six, which is a very welcome scheme, GPs have complained about the number of unnecessary visits they must accommodate. Likewise, if we increase free access to services, whether for pharmaceuticals or general practice, the question arises as to how we make those services efficient and ensure they are not used unnecessarily. I am not clear on whether we have examined that issue.

The other issue is efficiencies in our hospital structure. I deal with many people who work in the medical care sector and I have found there is a serious problem with morale among nursing staff, doctors, junior doctors and consultants. Many more people are retiring earlier than planned. Such are the pressures now being put on people right across the board that they want to get out, and they are getting out three, four and five years earlier than they had planned. This creates its own problems within the healthcare sector.

On the issue of consultants, if we want to deal with waiting lists we have to have a lot more people who have the ability to deal with the lists in a timely manner, and at the same time have the backup support. Over the last three or four years the HSE has taken on more than 12,000 extra people. I am not sure whether there was an overall plan to see exactly where people were needed and what needed to be prioritised. It appears to have been a bit hit and miss and a case of whoever could shout the loudest for extra staff got the staff. I am concerned that we are talking of putting more money into the health service without looking at prioritising from one to ten and asking where it needs to start with staffing and with the inefficiencies.

I have an issue with the lack of accountability in the health service. We discussed the patient safety Bill last week and I raised this issue. When we speak about the patient safety Bill and accountability it is aimed in particular at medical practitioners and nursing staff but I am not satisfied that we have any mechanism within the current structure of the HSE for accountability of managerial staff to the extent that we need. It is not referred to within the Sláintecare report but I may be wrong on this. I am concerned.

Another issue that causes huge inefficiencies in the health service is the moving of the deck chairs within HSE management. I have raised this previously. I am aware of one hospital that had ten hospital managers in 18 years. There is a lack of continuity in that process but nobody has asked why people are moving. Is there a problem with the job or with the pay? Nobody has looked at the movement of the deck chairs within the management and administration, where people are in a job for 12 months and then they have to move on to another job 12 months later. If a nurse starts in a position he or she is more likely to be in a particular area for a period of time, and likewise with other medical staff. There is continuity. We do not have that continuity in administration. I do not see where this whole management structure has been examined with regard to rolling out the long-term plan and accountability. How would the witnesses deal with that?

Reference was made in the graph to duplication, where some people have medical cards and health insurance, and other people who have neither a medical card nor health insurance. What are the exact percentages for these groups? I may have missed that and it would be helpful for me to have those percentages.

Professor Steve Thomas: I do not share all the Senator's concerns about inefficiency, but I hear them. In the Sláintecare report there is quite a large focus on changing the current inefficient system to one that is much more efficient. My worry is that if we allow the system to just persist as is then the inefficiencies will also persist. If one looks at what Sláintecare is trying to do, it is moving care from where it is currently provided into lower care settings, which is moving it out of acute care settings into community and primary care settings where it is being done much more efficiently, quickly and responsively. It is changing the skill mix around the delivery of some care where we are not so reliant on doctors to provide care. We are looking more at alternative provision of different kinds of care. The free GP and practice nurse access for children aged under six is an interesting case in point. We need to think creatively about how we provide that care so the system is not unnecessarily burdened, and see if we can we use more practice nurses in that kind of setting. We need to look at how we do that and think about it creatively.

Sláintecare is about doing things in a low-cost public care setting rather than in a high-cost private care setting. We presented interesting data last week from EUROSTAT around European healthcare expenditure. It shows that Ireland is the third most expensive country for voluntary health insurance spending per person. Ireland is actually the 12th most expensive in terms of Government funding per inhabitant. We must be careful not to believe the myths some people put out that we are spending far too much money. It is more about how and where we spend it. Sláintecare is critical to changing the way that is done. It requires transition and that is quite a difficult process, and sometimes slightly expensive in the short run. What it then delivers, however, is a system that operates far more efficiently.

Dr. Bridget Johnston: Following on from Professor Thomas's comments on efficiency, quite often people will say that we have to charge because if we do not - as the Senator said - then people may not use medication the way they should or they may visit the doctor when they do not need to. People do not necessarily know when they need care so it is better for them to access it and be sure of what is going on. It is about weighing the choice between unnecessary utilisation, making sure people do not go to the GP, do not take a drug they do not need or fill a prescription they do not use and crowding out those people who actually need to access care. We might look to improve efficiency on the one hand but we could end up with a very inefficient outcome in terms of people not accessing care until their problems are quite complex,

or accessing the care in a scenario that could have been dealt with much earlier. We need to be careful. There is no evidence of a sweet spot for charges that somehow eliminates all the unnecessary utilisation but does not keep people from accessing care they way they need to and in its most appropriate setting. There is evidence in Ireland that charges prevent people adhering to their medication and keep the poorest and sickest from visiting their GP. The charges are a direct deterrent. It is not necessarily true that introducing charges or maintaining charges at all costs will keep utilisation to only the necessary components. With free GP access there has been an increase in demand because of the access for children under six, and due to the expansion of care, but there is also a call in the Sláintecare report for increased primary care capacity and increased GP capacity to meet these needs, along with increased palliative care, home care services and other services to complement those needs. It is not just up to the GP. The GP can work with other healthcare professionals in tandem to provide this.

On the drugs issue, it is important to note that these medications will not be free under Sláintecare, but they are going to be affordable. People who are on medical cards or GP visit cards, or with other types of safety nets, should not pay a charge that we have already deemed they are unable to afford. They received a medical card because they are low income, or they have a chronic illness and cannot afford these. For households that have a certain amount of affordability for these drugs it is proposed that they are not charged more than that. We have pushed the thresholds up over the last number of years to a level that is not sustainable for many households.

Senator Colm Burke: Will Dr. Johnston clarify the point about pushing?

Dr. Bridget Johnston: I apologise that I left that note off. The percentages actually drop when we look at the figures of those with no coverage. There was 15% of households within that breakdown that could not afford their healthcare. In 2009-2010 it was nearly 13% of households that could not afford their healthcare expenditure, which was their out of pocket charges and their private health insurance premiums. The figure was 12.2%, which is illustrated in the yellow section of the document I provided. This means they had no coverage, neither a medical card nor private health insurance. This figure dipped to 9.8% in 2015-2016. This dip comes with a huge health warning, however, because we what we are really capturing is the huge amount of unmet need. Most households cannot even afford to put themselves into financial hardship because they do not have the money to spend on private care or insurance premiums. We have good evidence to support the fact that unmet need is growing in Ireland. A recent survey found that Ireland now has the second highest rate of unmet need for healthcare in the EU with 40.6% of adults over the age of 15 saying they had an unmet need for healthcare in at least the last 12 months due to cost, distance or waiting lists. Only Latvia is higher than us now.

Senator Colm Burke: With regard to the drug charges, is there not a monthly cut-off point beyond which people do not pay for their drugs? Is that a cut-off of €134?

Dr. Bridget Johnston: Yes, there is.

Senator Colm Burke: Has there been an increase?

Dr. Bridget Johnston: There was an increase in the threshold over a number of years.

Dr. Sara Burke: There was an increase between 2010 and 2015-----

Senator Colm Burke: It has since dropped.

Dr. Sara Burke: -----but it has come back down.

Professor Steve Thomas: It has not come back all of the way down.

Dr. Bridget Johnston: It is not enough to reach the threshold where it is more affordable for households.

Senator Colm Burke: I am not suggesting there should be increased costs. I am asking how do we create an efficient service, one that is delivered and, at the same time, make sure there will not be unnecessary use of it? That issue came home with the introduction of free GP care for those under the age of six years. If we continue to increase access to free GP care, we will also have to meet that challenge. That is the question. I am not asking about increased costs or anything else. I want to reduce them, but how do we deal with increased demand, as occurred in the case of those under the age of six years?

Professor Steve Thomas: In some ways, it was a useful test case for how we change entitlements and how the system responds. There is much to be learned from the case study. We need to think carefully about what the capacity of the system will look like. Where people do not necessarily need to go directly to their GP, could care be provided by other healthcare professionals? There has to be capacity in the system to do that, which is why Sláintecare is to invest in it. It is a case in point to ensure the appropriate learning from the policy.

Senator Colm Burke: I want to touch on community care services. I agree fully with what has been said, but I spoke to a GP in a community care centre where a physiotherapist is now employed by the HSE. It was taking anything up to six weeks for the GP to get an appointment for a patient with the physiotherapist. He could telephone a physiotherapist and get a private appointment within 24 hours. I agree fully that we need to introduce community care services at a far higher level. How do we make sure we are delivering services in a timely manner and that it is not just about employing people? That is also a challenge.

Chairman: I have a point about services for those aged under six years. Nobody is arguing about the expansion of free care services or services at low cost. In the past few years, however, we have seen the expansion of free GP care to those aged under six years - about an extra 240,000 children - persons in receipt of domiciliary care allowance and carer's allowance. At the same time, there was a reduction of 38% in resources for general practice. In the case of those aged under six years, what has happened is that the visitation rate has increased and general practice does not have the capacity to deal with the increase. As a result those aged under six years end up being brought to out-of-hours services which also do not have the capacity to deliver free care services. The children then end up in emergency departments. The presentation of children aged under six years in emergency departments has, therefore, increased since they were provided with free GP care. Children have not got any sicker in that time, but they have an entitlement to free GP care and if they do not receive it in general practice or out of hours, they will present at emergency departments. Entitlement can be expanded, but it will have that consequence if it is not matched by an expansion of capacity. Why would an emergency department see more children aged under six years when they have an entitlement to free GP care? It is because general practice does not have the capacity to take them on. That is where the policy does not match the practicalities.

We have touched on some aspects of the Sláintecare implementation strategy. Lost in translation, as I put it, has been the funding element and the issue of entitlement versus eligibility and the blurring of the lines in that regard. There has also been a loss of urgency. I do not get

the impression from the Sláintecare implementation strategy that there is urgency. We are now two and a half years into the process and we still have not seen any policy change. Are there other elements the delegates can identify that have also been lost in translation? It is a broad question.

Professor Steve Thomas: The one about which we have been talking is ensuring more healthcare professionals in the primary and community care setting. Sláintecare looks to expand by about 5,000 - 6,000 in its entirety - the number of occupational therapists and public health nurses, but I do not see any indication that that element has been taken on board. The staffing of primary and community care settings is the critical component that will unlocks so much else if we want to move from providing care in acute care settings. That has to be a priority, but I do not see it being picked up on.

Chairman: I thank Professor Thomas.

Deputy Bernard J. Durkan: What is interesting about the graph is that it includes a breakdown of the income categories for those with full medical card and GP card coverage. It is interesting to see the proportions in each.

Dr. Sara Burke: There is a health warning in that it includes just the proportion of the population who are experiencing financial hardship. It accounts for 14% or 16% of the population.

Deputy Bernard J. Durkan: It is interesting.

Dr. Sara Burke: We can send the figures for the entire population to the Deputy.

Dr. Bridget Johnston: The household budget survey also has its limitations in the data provided. They do not go into residential care settings. We are not capturing persons who have been living in nursing homes or other residential settings. That is one of the limitations of the survey. It is, however, a first look. Nobody has before examined how affordable is the expenditure we are asking households to incur.

Deputy Bernard J. Durkan: I thank Dr. Johnston.

Chairman: I thank the Deputy. I also thank Dr. Sara Burke, Dr. Bridget Johnston and Professor Steve Thomas for coming at short notice. I thank them for their input into the Sláintecare process and the analysis of the outturn so far. I am sure we will meet again.

The joint committee adjourned at 1.20 p.m. until 9 a.m. on Wednesday, 10 October 2018.