The Joint Committee met at 5.10 p.m.

MEMBERS PRESENT:

| Deputy Ciara Conway,                | Senator Colm Burke,                  |
| Deputy Regina Doherty,             | Senator John Crown,                  |
| Deputy Peter Fitzpatrick,          | Senator Jillian van Turnhout.        |
| Deputy Seamus Healy,               |                                       |
| Deputy Billy Kelleher,             |                                       |
| Deputy Eamonn Maloney,             |                                       |
| Deputy Sandra McLellan,            |                                       |
| Deputy Caoimhghin Ó Caoláin,       |                                       |
| Deputy Mary Mitchell O’Connor,     |                                       |

DEPUTY JERRY BUTTIMER IN THE CHAIR.
The joint committee met in private session until 5.21 p.m.

**Health Service Plan 2014: Minister for Health and HSE**

**Chairman:** I remind members, delegates and those in the gallery to either turn off their mobile phones or put them in flight mode.

I welcome the Minister for Health and his officials, Mr. Tony O’Brien and his officials, members and those in the gallery to our first meeting of 2014. I wish everybody a happy, prosperous, tranquil and gentle new year. I also hope the committee will have a good year. I thank all committee members for their work last year, as well as the Minister, Mr. O’Brien and the staff of the Department of Health and the HSE. I pay tribute to HSE staff who demonstrated tremendous commitment on behalf of the people in 2013 and thank them for the service they provide at different hours of the day and night, which sometimes is not noticed or commented on in a positive manner.

The purpose of the meeting is to discuss the HSE’s service plan for 2014. I remind members that we will have our quarterly meeting with the Minister and Mr. O’Brien on Thursday and I would appreciate it if they could defer questions on other matters until then. I do not wish to begin the year in an adversarial manner and hope we can proceed in a positive, calm, tranquil and collegial way. A copy of the service plan has been circulated to all members, while the opening statements and supporting documents were communicated to members prior to the meeting.

Witnesses are protected by absolute privilege in respect of their evidence to the joint committee. However, if they are directed by it to cease giving evidence on a particular matter and continue to do so, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against a person or an entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice and ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official by name or in such a way as to make him or her identifiable.

I have received apologies from Deputies Catherine Byrne and Regina Doherty and Senator Imelda Henry, while Deputy Robert Dowds has to attend the meeting of the Joint Committee on the Environment, Culture and the Gaeltacht. I call on the Minister to make his opening remarks.

**Minister for Health (Deputy James Reilly):** I wish everybody a happy and healthy new year.

I thank the joint committee for giving me the opportunity to make this presentation on the 2014 national service plan. I am joined by my colleagues from the Department of Health, Ms. Bairbre Nic Aongusa, assistant secretary, and Ms Fiona Prendergast and Mr. John Keegan, principal officers. I am also joined by the director general of the HSE, Mr. Tony O’Brien, and his directors Ms Laverne McGuinness, Mr. Thomas Byrne, Mr. John Hennessy, Mr. Philip Crowley, Ms Stephanie O’Keeffe and Mr. Barry O’Brien.

This year’s service plan has been prepared at a time of unprecedented challenges for the health system which arise as a direct consequence of the emergency financial situation in recent
years. It is important to acknowledge the significant improvements in productivity and the increasing range of services delivered during this period against a backdrop of significantly reduced budgets and workforce numbers. The health system has also had to support increasing demand for its services during this time, with the population of the State increasing by 8% and the proportion of persons aged 65 years and over increasing by one fifth.

Managing the impact of these significant financial, resource and demographic pressures on the health system in the years ahead, while delivering safe, quality health and social care services to the public, will only be possible by way of a reformed health system that provides access according to need rather than ability to pay, for best health outcomes from the available resources and treats patients at the lowest level of complexity that is safe, timely, effective and efficient and as close to home as possible. A 20% budget reduction and a 10% reduction in staff numbers form the backdrop to the service plan.

I will continue to deliver the Government’s programme of health reform – the most comprehensive programme of reform since the foundation of the State – throughout the year. I am pleased that the HSE has placed the advancement and implementation of these reforms at the centre of its planning for 2014.

The following key elements of the health reform programme are built into the fabric of the 2014 service plan: phased implementation of a money follows the patient funding system in hospitals, with payments to be made to participating public hospitals on the basis of the level of inpatient and day case activity that they complete - in other words, if no patients have been treated, no funding will be available to the hospital; the transition to hospital groups, including the appointment of new group chief executive officers, CEOs, where required, the development of a memorandum of understanding between the HSE and each group and the development of a programme for implementation of hospital groups; the establishment of new community areas, with associated governance and organisational arrangements, following the completion of the review of integrated service areas - I refer to Mr. Pat Healy who has done great work with his team in this regard; implementation of new internal management structures, with specific programmes relating to shared services, procurement, human resources and information; establishment of an interim patient safety agency, initially on an administrative basis, within the HSE structure; development of commissioning functions, with the aim of achieving the greatest progress on a commissioner-provider split, prior to the introduction of statutory functions; and formation of a cross-divisional working group for health and well-being aimed at identifying the most effective model for the delivery of health improvement gains for the population in the context of a health care commissioning environment.

My overriding priority in delivering these key health reforms across the health sector this year is patient safety. I very much welcome the fact that patient safety and improving the quality of services to the people of Ireland are at the core of the service plan and that all health staff, individually and collectively, have a responsibility under the plan for the safety and quality of services they deliver to patients and service users in their care and must integrate this commitment to safety and quality into their core work practices. The service plan provides for the development and use of a comprehensive set of quality and safety indicators to measure the quality and safety of services, with a particular focus this year on the priority areas of medication safety, health care associated infections, HCAI, and the national early warning score, NEWS. It also looks to implement the recommendations made in the reports of the HSE and the Health Information and Quality Authority, HIQA, on the maternal death at Galway University Hospital by targeting necessary patient centred improvements in maternity care. These health reform
and patient safety priorities set out in the service plan are critical in order to maintain sustainable levels of service delivery to the population into the future and build on the progress made in recent years.

The 2013 edition of *Health at a Glance* published by the OECD shows that Ireland continues to make substantive headway in improving health outcomes. Mortality due to cancer fell by 21%, ischemic heart disease by 59% and cerebrovascular disease by 54% between 1990 and 2012 and in all three instances the rates of improvement in Ireland were above the OECD average. Since 200 life expectancy in Ireland has increased by four years to reach 80.6 today, again above the OECD average. I thank the men and women who deliver our health and social care services for maintaining and, in many cases, improving the ever expanding range of services provided for the general public, despite reducing resources in recent years. Their efforts have been highly commendable in these most challenging of times. The reform process is well under way and gathering momentum.

Chronic diseases such as cancer, cardiovascular and chronic respiratory disease and diabetes are the leading causes of mortality and account for more than three quarters of all deaths in Ireland. The risk factors associated with the increased prevalence of chronic diseases such as obesity, lack of exercise, unhealthy eating patterns, over-consumption of alcohol and use of tobacco products are generally preventable. To address these areas of concern, Healthy Ireland, the Government’s national framework for improved health and well-being published in 2013, sets out a whole-of-government and cross-sectoral approach to address the demands placed on health and social care services from the growing incidence of chronic illnesses, together with the challenges of an ageing population. The commitment in the 2014 service plan to the health and well-being reform agenda set out in Healthy Ireland is critical in enabling the required shift in emphasis towards health prevention, promotion and improvement in the years ahead.

The revised gross expenditure health ceiling is €12.584 billion for 2014. This figure does not precisely correlate with the funding set out in the national service plan owing to the transfer of the children and families budget, €537 million, to the Department of Children and Youth Affairs. Child and family services are encompassed within the national service plan, but funding for these services will be channelled through the newly established Child and Family Agency. In addition to this adjustment, the revised Estimate for the HSE includes additional health funding of €47 million over and above the budget provision and €22 million in funding transferred to the HSE Vote from the Vote of the Department of Health for the drugs programme. The HSE is required to achieve savings measures of €619 million next year to remain within the 2014 health expenditure ceiling. The savings target has reduced from €666 million announced in the budget to €619 million as a consequence of the additional €47 million in funding allocated to the HSE Vote in the Revised Estimates Volume.

I have agreement at Government level that the medical card probity savings target this year will be €23 million, not €133 million previously pencilled in for this measure. That €133 million comprised €20 million already identified for probity measures and a further target of €113 million included in the budgetary arithmetic. It is now accepted, as a result of the objective verification process carried out on this €113 million probity target at my request since budget day, that this figure did not sufficiently take into account the extent to which medical card centralisation and already implemented probity measures in the past few years had already achieved much of what could be achieved in that regard, given, in particular, the Government’s affirmation that no changes whatsoever were to be made to general medical card eligibility criteria. The Government has made it very clear that there will be no change to the current
guidelines for general medical cards and is committed to ensuring those entitled to a medical card receive and retain one.

The medical card scheme is demand-led. We have to ensure those entitled to medical cards continue to hold them. At the same time, we have an obligation, under the legislation, to ensure those whose situation has improved and, therefore, are not entitled to a medical card are not incurring a cost to the health service. I am aware that there has been public concern that, under the probity measures, medical cards may be indiscriminately withdrawn or cancelled. Nothing could be further from the truth. It is important to note that no person who meets the eligibility conditions for a medical card will be affected by this measure. To this end, the service plan provides €35 million to meet the cost of new applications for medical and general practitioner visit cards in 2014.

The implementation of the Haddington Road agreement, commenced on 1 July 2013, is now well advanced in most sectors and already delivering on its objectives. The Government is satisfied that the measures negotiated across all sectors, including the health sector, will deliver the targeted savings of €1 billion over the lifetime of the agreement. The agreement involves a demanding set of targets for the health service which accounts for approximately one third of the overall public service workforce. Naturally, the resultant savings to be realised in that sector form a significant part of the overall €1 billion target.

Throughout the talks process which resulted in the Haddington Road agreement senior officials from my Department and the HSE played a key role in supporting the Department of Public Expenditure and Reform in the negotiations at both central and sectoral level in agreeing the finalised planned measures for the health sector. They have continued to work closely with officials in the Department of Public Expenditure and Reform since the agreement came into force. The realisation of these savings in the health sector will, of course, be challenging and the focus and responsibility of management are on the delivery of these savings through the implementation of the various measures and other flexibilities for which the agreement provides. A HSE national assurance and support team is working with managers to ensure measures to deliver the necessary savings are implemented.

The amount of €108 million is an integral part of the overall savings target for the health sector. The €108 million pay-related savings target will be subject to a separate process and, of necessity, remain unspecified and be held centrally by HSE management until a procedure is in place setting out how these savings are to be achieved. These measures are to be determined with the assistance and support of the Departments of the Taoiseach and Public Expenditure and Reform. There is no question of health employees being required to take additional payroll reductions other than those required under the Haddington Road agreement.

There are significant service developments included in the 2014 service plan. In line with the programme for Government commitment to universal health insurance, a GP service, without fees at the point of use, will be provided for the estimated 240,000 children aged five years and under in 2014. Additional funding of €37 million was provided in the budget to meet the cost of this measure. In addition, €20 million has been earmarked this year to meet programme for Government commitments for mental health services. This funding will allow for continued strengthening of community teams, increased suicide prevention resources and clinical programme development and implementation and support an additional 250 to 280 posts. These posts are in addition to the approximately 900 posts approved to date under the programme for Government commitment to mental health service development.
The 2014 HSE service plan includes an additional €178 million for vital service developments, including the €35 million for additional medical cards to which I have referred and €30 million in acute service areas across emergency department, inpatient, day care and outpatient services which continue to experience increased service demand. Other priority service areas addressed in the plan at my specific request include the continued roll-out of diabetic retinopathy screening and treatment, involving additional funding of €4.5 million in 2014; funding to provide a service to undertake bilateral cochlear implants, with a particular focus on five-six year olds in 2014, involving additional funding of €3.2 million in 2014; in the area of disability, there is additional funding of €10 million for young people with a disability leaving school or training and needing emergency and residential placements; there will be additional organ donation and transplantation resources of €2.92 million in 2014 to benefit patients and their families; and funding of €1.2 million in 2014 to allow discharge from hospital and provide required care in the community for special care children who have had to undergo tracheotomies to allow such children to grow up at home, not in hospital. On the point of funding for young people with a disability leaving school, everyone agrees that the parents of such children leaving school should not face a summer of uncertainty as to whether their children would have a placement. This funding will alleviate the concerns of these parents.

On publication of the service plan on Wednesday, 18 December 2013, I welcomed the support of my colleagues in the Government in dealing with some of the concerns that arose following budget day. These concerns were addressed by way of the additional €47 million in health funding provided by the Government in the Revised Estimates Volume, the reduced medical card probity target of €23 million, also agreed to by the Government, and the further process, now in place, in regard to the €108 million in pay-related savings. The HSE has confirmed that its primary focus throughout the year will be to continue to deliver the same level of front-line services with a reduced budget, while ensuring quality and safety is paramount. In the context of a reduced overall budget, the director general has also highlighted that the Haddington Road agreement provides an important mechanism by which the service plan can be delivered, and I fully endorse these comments.

I would like to conclude by again expressing my deep appreciation for the hard work and commitment of staff across the health and social care services. Given the reduced human and financial resources available over recent years, the achievement of the health service in terms of maintaining quality services and implementing reform during these most difficult of times is deserving of the highest praise. I am confident we can continue to build on these achievements throughout 2014.

Chairman: Thank you. I would now like to call on Mr. Tony O’Brien, the director general of the HSE, to address the committee.

Mr. Tony O’Brien: Good evening, Chairman. I would like to add my own seasonal good wishes to everyone present. The national service plan was formally submitted to the Minister for Health on 25 November 2013, in line with the provisions of the Health Act 2004, and is the first annual plan presented by the directorate of the health service following the enactment of the Health Service Executive (Governance) Act 2013. The service plan is also the first since the publication of the report of the Mid-Staffordshire NHS Foundation Trust public inquiry, known as the Francis report, in February 2013, the findings of which highlighted in the starkest of ways the need for a renewed collective commitment to providing the highest quality care in the safest of health care environments. The Keogh report which followed again identified poor standards of patient care in a further 14 hospital trusts and set out the help and support required to assist
health care providers in accelerating improvements in the quality of care provided while also tackling the causes of poor care. Similar findings and recommendations were echoed in the investigations by the HSE and Health Information and Quality Authority into the safety, quality and standards of services provided to patients after the death of Ms Savita Halappanavar at Galway University Hospital.

The service plan for 2014 sets out the type and volume of services, as required under legislation, which will be delivered within the funding provided by the Government. At the heart of the service plan is the commitment to the delivery of safe, high-quality health and personal social care to patients and clients and the reform of our services. The gross current voted Estimate for the health service in 2014, including children and families, is €13.12 billion. The reduction in the health service budget between 2008 and 2013 amounted to €3.3 billion, and when coupled with reductions in 2014 the total budget reduction over six years amounts to almost €4 billion. In its initial assessment of health service requirements for 2014, the HSE approved a formal submission to the Department of Health reflecting the need to sustain safe services at the current levels, while at the same time responding to known pressures, demographic requirements, critical service priorities, programme for Government commitments and service developments and quality initiatives.

There is an underlying projected deficit of €419 million, including full-year costs for 2013 developments, coupled with a reduction to our funding base and additional savings targets of €619 million. This means the health service is facing a significant financial challenge in 2014. This challenge comes at a time when the demand for health services is increasing every year, which in turn is driving up costs. Managing ill health resulting from an ageing population and an increase in chronic conditions is a major driver of health care costs. Future projected increases in chronic disease are largely attributable to behavioural factors that the Minister has already listed in his opening remarks.

In 2013 the Government published Healthy Ireland, a cross-government framework for improved health and well-being. A 2014 service plan priority will be development of a three-year health service implementation plan for Healthy Ireland, and this will be led by the new health and well-being division, whose director is Dr. Stephanie O’Keeffe, who is with us today. During the course of this service plan, it will not be possible to meet fully all of the growing demands being placed on the health services. In particular, some service priorities and demographic pressures may not be met. However, the budget management approach outlined below has allowed the health service to invest in a number of significant and critical service priority areas in 2014, while at the same time ensuring that the health service maintains patient safety and improves the quality of services, protects core services, and drives the delivery of the reform programme.

Quality and safety will continue to be a system-wide priority for the health services in 2014, and this is threaded throughout the national service plan. The key message is that patient safety is paramount. All health service staff, individually and collectively, have a responsibility for the quality of the services they deliver to the patients and service users in their care and must ensure that maintaining quality and safety is core to their work and practice. A number of key quality and patient safety initiatives will continue in 2014, including improving patient experience, preventing health-care-associated infections, further implementing national early warning score systems, and improving medication management.

Our approach to the reduction in the gross Estimate of €272 million, or 2%, includes the following. Additional savings of €619 million will be made, of which €108 million pay savings
remain unspecified and will be held centrally pending a separate verification process. A further €80 million in savings relating to the Haddington Road agreement will also be held centrally in the first instance pending an assessment of the most appropriate allocation of the savings across each service location. This exercise is currently under way. There is also a projected incoming deficit of €419 million, which includes the full-year costs for 2013 service developments.

In developing the service plan for 2014, a multifaceted approach to budget management was adopted in order to protect core services. It is important to stress that the principal focus is to continue to deliver the same level of front-line services with a reduced budget, particularly in areas such as provision of home help hours, home care packages and disability services, while at the same time ensuring that quality and safety is not compromised in any way.

The specific elements of this multifaceted approach to budget management include a reduction in the lump sum provision for pensions, which will be used to offset, in part, the incoming deficits from 2013; making use of savings which will accrue from the phased implementation of new developments during 2014; and additional savings targets of €129 million in areas such as procurement at €30 million, shared services at €10 million, value for money initiatives at €10 million, hospital reconfiguration at €7.5 million, energy efficiency savings at €15 million, and the full delivery of cost containment plans for hospitals, initiated in 2013, at €56.5 million. Specific actions in respect of the additional €619 million savings target include pay and flexibility reductions totalling €268 million, of which the Haddington Road agreement will facilitate up to €140 million. As mentioned previously, €108 million of this relates to unspecified savings and will be held centrally pending a separate process.

By adopting this approach, it will be possible to provide funding of €304 million for a range of initiatives, of which €178 million will be invested in a number of new critical service developments, initiatives to meet some demographic pressures and programme for Government commitments. A further €126 million will be provided on a once-off basis to address the full-year cost of developments started in 2013, which will continue in 2014. Full details of these new investments are set out in appendix 1 of the service plan and are included in the printed version of my statement. I will not repeat the list that the Minister has already covered. However, I would like to stress that the health service will provide home help and home care packages to approximately 56,000 recipients, maintaining the 2013 approved service levels. The nursing home support scheme will continue to support more than 22,000 people in long-term residential care at a cost of €939 million. In shifting the emphasis of the model of care to home and community supports, we will maintain services to allow an additional 1,000 older people to continue to live in their own homes.

Health reform is also a critical priority for the health services in 2014, and a systems reform group has been established to oversee the governance and enable the management of change across the broad portfolio of reform projects being undertaken. These reform projects include continued implementation of the national clinical programmes; phased implementation of the money-follows-the-patient approach to the funding of acute hospital services; transition to hospital trusts and community care organisations; the development of commissioning functions; the development of a three-year implementation plan for Healthy Ireland; the establishment on an administrative basis of the new patient safety agency; the establishment of the new Child and Family Agency on 1 January - I would like to take this opportunity to wish our colleagues well in that new agency - and the further roll-out and reform of shared services.

In the area of human resources, since September 2007 the health service has reduced its workforce by 12,505 whole time equivalents, WTEs. During 2014 a target of approximately
98,000 WTEs has been set for the health service workforce. This challenge will require a focused approach to management of our staff resource while controlling payroll and related costs. In this regard the Public Service Stability Agreement 2013-2016, the Haddington Road agreement, is a key enabler to deliver this service plan and to health services reform, having regard for financial and human resources.

The national service plan is set out on the basis of the new service divisions, which are acute hospitals, primary care, social care, mental health and health and wellbeing, established in 2013. Operational plans are currently in development for each of these divisions and will be published in due course.

In conclusion, it is acknowledged that the 2014 service plan has been formulated in the context of one of the most financially challenging years yet faced by the health service. The implications of the combined budget reductions and additional savings targets mean that a specific financial management strategy is required in 2014 to ensure the impact of the budgetary challenge on service delivery is kept to a minimum.

During the course of this service plan, it will not be possible to fully meet all of the growing demands being placed on the health services. In particular, some service priorities and demographic pressures may not be met. However, the budget management approach outlined above has allowed the health service to invest in a number of significant and critical service priority areas in 2014. Implementation of the health service reform programme is also key.

I wish to take this opportunity to acknowledge the health service employees’ contribution and continued commitment to improving patient experience and outcomes, despite reduced budgets and staffing levels. I conclude by reiterating that the health service is committed to safe quality care underpinned by clinical effectiveness. To this end, the national service plan focuses on quality and safety, service reform and service delivery. This concludes my opening statement.

Chairman: I beg the indulgence of the committee to congratulate our Vice Chairman, Deputy Ciara Conway, on her wedding.

Deputy Billy Kelleher: I welcome the delegation, the Minister and the director general of the HSE. I wish everyone a happy new year. I welcome the two opening statements. It does not unearth anything earth-shattering in the context of the framework laid out for 2014 but shows it will be very challenging, as outlined by the director general. It also shows a big hole in the Estimate in underpinning the service plan in funding. We are talking about an underlying budget deficit of €419 million, coupled with savings to be identified of €619 million. In previous statements, the director general has referred to €1 billion as the overall adjustment required to live within the budget figures announced. That was subsequently deleted but it does not get away from the fact that we are facing a budget reduction of €1 billion. I would like some clarity on why the €1 billion figure mentioned in previous times has now been dropped, even though the only additional funding I can find is the €47 million identified in the Revised Estimate. The director general said previously that it will not be possible in 2014 to deliver the plan and now he says it will be very challenging. I find it hard to believe that the sum of €47 million moves it from being almost impossible to very challenging in the overall context of a €13 billion budget.

We were led to believe there was uproar at Cabinet when the first draft service plan was presented by the Minister for Health to the Cabinet. The reason we were told or were led to believe was that Ministers had concerns about the wording of the foreword signed off by Mr.
O’Brien, which stated

It will not be possible in 2014 to fully meet all of the growing demands placed on the health services. In particular, the level of investment required to meet many of the critical service priorities or respond to many of the demographic pressures identified.

That was subsequently amended to read:

It will be very challenging in 2014 to fully meet all of the growing demands being placed on the health services. In particular, some service priorities and demographic pressures may not be met.

Twice in Mr. O’Brien’s presentation, he has gone for the original wording and I find it strange that it was taken out of the original wording even though Mr. O’Brien has twice mentioned the exact wording that was deleted after political discussion at the Cabinet table. I find it strange and I wonder why it is the case.

It is identified that there will be €108 million of unspecified savings and that there will be an independent verifiable process to assess how the savings will be achieved. How long will it take to identify where the savings will be realised and whether they can be achieved? If they cannot be achieved, other areas must suffer to ensure we come in under the budget targeted in the HSE service plan. When will the savings be identified and, if they cannot be identified, will it require a Supplementary Estimate? Will funding that has been clearly identified in the HSE service plan be withdrawn, as has happened in previous times in respect of disability and mental health? These areas were targeted in previous times when the books would not balance. It is important to get clarity on this point very quickly.

Fianna Fáil welcomes the change in respect of the probity probe into medical cards. It never ceases to amaze me that it could have been included in the original Estimate proposals because it did not make sense. I do not believe there are so many medical cards in circulation that should not have been in circulation. If that is the case, it is an indication of sloppy awarding of medical cards. We welcome the rollback. The Minister also referred to medical cards and how people are entitled to them. No one disputes that everyone entitled to a medical card under the income guidelines set out in the 1970 Health Act will receive a medical card. These people are legally entitled to them but the key area concerns discretionary medical cards. By any adjudication, the number of medical cards and GP discretionary cards has decreased from 96,000 to 57,000 over the past three years. There is a targeting of discretionary medical cards, even though we are consistently told it is not the case. Most Deputies and every organisation I encounter say it is almost impossible for some people, who had previously been awarded discretionary medical cards, to get medical cards. We must revisit this.

The Minister talks about reform continuing apace. I must question that in view of the fact that we are now facing into the fourth year of this Government. The White Paper on universal health insurance has not been published and it is a key underpinning part of any potential further reform. The Minister talked about setting up hospital trusts and how money follows the patient. This is an important area and at this stage we should see what is a central plank of Government policy in terms of the reform of the health services and how they are funded.

Consultant-led clinical care teams are a central plank in the delivery of health care. Where there are consultant-led clinical care teams they work very effectively. We must acknowledge that. Anecdotally, I have heard of a number of incidents where it is more difficult to recruit
consultants. Is that the case? Is it difficult to attract consultants to this country and difficult to retain consultants? If so, why is this the case? We all know we must increase the number of consultants in the health services to ensure we have delivery of care.

Mental health is grossly underfunded. No matter what way we try to argue or spin this issue, or whether one Minister of State had to threaten to resign to get €20 million included in the HSE service plan, the bottom line is that it is grossly underfunded. A Vision for Change is effectively being used as a mechanism for closing services as opposed to enhancing them. We must genuinely consider that issue. If services are to be reduced in an area, the full recommendations of A Vision for Change should be implemented rather than the parts recommending the reduction in acute or community beds and other areas. A Vision for Change should be fully rolled out rather than using it in a guise in order to close services.

**Deputy Caoimhghín Ó Caoláin**: I welcome the opportunity to address this plan at last, as we had hoped to be in a position to address it prior to the Christmas recess. I welcome Mr. O’Brien’s usage of the phraseology that was first submitted for consideration in a memorandum to the Cabinet indicating that “it will not be possible to fully meet all of the growing demands being placed on the health services”. He has stated that twice in this evening’s contribution, and it is the accurate and truthful position. It is very unsatisfactory and unacceptable that the formulation was changed to a phrase such as “very challenging in 2014 to fully meet all of the growing demands.” This change happened not because of an assessment by Mr. O’Brien but because of political choice, and the more sanitised version was released by the Minister and published in the 2014 service plan. I expect the Minister to stand up for the health services and state very clearly to his Cabinet colleagues that €690 million in cuts in 2014 is unsustainable. I also expected of Mr. O’Brien that in the assessment he provided initially, he should have stood up to the Minister and insisted that the phraseology he employed in his informed position as director general should have stood. I welcome his utilisation of that formula here this afternoon.

There was a comment regarding the radio interview of 22 December, with Mr. O’Brien indicating that he was given no source for the proposed figure of €113 million in probity cuts to medical cards, since changed to €23 million in the service plan as presented. The figure of €113 million did not come from either the health department or the HSE. That raises real and serious questions as to the methodology of determining budgeting for the health services and planning on a year-to-year basis. I have repeatedly asked in the Dáil and here where the figure of €130 million in so-called medical card savings came from, so will somebody give the full, detailed and truthful answer? I note from the Minister’s contribution that this is “pencilled in”, but that is not acceptable. We want to know from where that figure came, and nobody need take any solace from the fact that we are now considering a figure of €23 million rather than €113 million. Many people who have depended on discretionary medical cards in particular have not retained their cards, and many others who would have hoped to receive their cards will not do so during the course of this year.

In the context of €4 billion having been taken from the health budget since 2008, with a further planned reduction in staffing, financial and human resources are being depleted. Mr. O’Brien indicated in his closing remarks the impact of the loss of approximately 12,500 people within the Health Service Executive. He did not indicate the projected cuts in 2014 and rather depended on the figure that might remain, but we will see a further 2,600 whole-time equivalents going in 2014. That is what the service plan projects. How can the health service, with all the financial cutbacks signalled, be able to carry out the level of service it currently gives, with patient safety in such high demand? There has been affirmation from both voices heard this
afternoon, saying that such safety is the principal and guiding goal at all times. How can this be achieved if the Government continues to remove such a significant number of people from within the service? It is not sustainable.

I welcome the introduction of GP cards for children aged five and under but, unfortunately, we must consider the issue in the context of overall primary care cuts. By my calculation, they could amount to something of the order of €294 million. When can we expect the roll-out of the GP entitlement to all children aged six and under in the course of 2014? I note the Government is to take an additional €43 million out of the pockets of medical card holders in increased prescription charges, but when that figure is compared to the anticipated savings of some €50 million due to generic substitution and reference pricing, it puts into context just how pitiful the savings are with regard to generic substitution and reference pricing. The real potential is not being realised at all.

On that note, how do the Minister and the director general account for the failure of the HSE to move more quickly in setting reference pricing for medicines under the long-overdue legislation we passed last year? I have only to reference the recent *Sunday Business Post* article which details the figures, indicating that a range of drugs placed on the interchangeable lists by the Irish Medicines Board have not yet had reference prices set by the HSE. We are failing to realise what could be saved. Will an answer be given to the question? Do the witnesses accept that the entire process has been far too slow at a time when we need additional resourcing and funding? We are not moving quickly enough to realise the real savings that can be brought about. The money is to be taken from the pockets of medical card holders almost to an equivalence of what can be saved in this area, and that speaks volumes in my mind.

I am also very concerned that the service plan states that no additional funding is being provided for new nursing home places in 2014. That is a very worrying aspect, as there are already large waiting lists for places under the so-called Fair Deal scheme. This plan spells misery for thousands of people, and it is not that any saving is being made. There are approximately 600 people who may be holding beds inappropriately across our acute hospital network because they are unable to return home or access beds in the nursing home network.

Within the very short time available to us it is impossible to cover all of the critical areas. I wish to ask about the bilateral cochlear implants programme signalled for 2014, which I very much welcome. Nevertheless, the sum falls far short of what might have been required to set in place a full bilateral cochlear implant programme, not only for those waiting but also for those who may now present. Will there be a commitment to fully funding and rolling out that programme in 2015, and will the delegation confirm when the programme will be up and running in 2014? What level of provision of implants will there be and what number of young people is hoped to be catered to in the course of the year? Lastly, what is meant by €108 in “unspecified pay savings”?

**Deputy Seamus Healy:** I welcome the Minister and his Department staff, as well as Mr. O’Brien and the HSE staff. I compliment the HSE staff throughout the country who provide services, as well as related staff, services and communities funded through this budget. They are under significant pressure and work above and beyond the call of duty on a daily if not hourly basis. It is important that we understand that. We compliment the staff on the work they are doing under such pressure. This is the third year in a row we have been presented with an unsustainable budget and service plan. It is clear even at this early stage that additional funds will have to be made available later in the year, as happened last year and the previous year. The figures Mr. O’Brien has given indicate a reduction of €4 billion in funding from 2008 to 2014.
and a reduction in staff numbers by 12,500. That means staff on the ground are under huge pressure. People find it difficult to be seen at outpatient clinics and to get into hospital. For the first year in a few years we have had an increase in the trolley count in emergency departments.

I seek clarification from Mr. O’Brien of the figures under discussion. What is the total amount envisaged in savings or cuts? It would appear from Mr. O’Brien’s submission that we are talking about more than €1 billion in cuts. I support the request by other speakers for an indication of what the sum of €108 million relates to. Mr. O’Brien said a number of times in his submission that the health service would not be able to meet all the demands placed on it. I would like him to elaborate on what he means.

The sum of €56.5 million relates to cost containment plans for hospitals. To what does the global figure relate? Reference is also made to savings of €7.5 million on hospital reconfiguration. Could Mr. O’Brien indicate to what that figure relates? Some chairpersons have been appointed for hospital groupings and CEOs are in the process of being appointed. Is there a timeline for the appointment of the boards?

Before Christmas I inquired about the cost of employing agency nurses and junior doctors. I would like to know the figure relating to agencies that is part of the plan. I am interested in hearing the cost of employing agency nurses and particularly junior doctors. I have not yet received a reply to the request I made before Christmas. I urge that there be a review of the central recruitment process because it has given rise to difficulties at local level right across the country. There is scope for local recruitment of staff given the evident difficulty at central level.

Probity and medical cards have been dealt with by previous speakers. There has been a change of policy with regard to the granting of discretionary medical cards. I see it every day in my constituency office and hear about it every day from colleagues on all sides of the House. There is no doubt that families who have held full medical cards for years are now losing their cards. They have been targeted and their cards are being withdrawn as we speak. That is happening on a daily basis.

In the course of his opening statement the Minister referred to medical card limits. The limits for medical cards have not been increased since 1 January 2006. They are now out of date. Furthermore, there was a reduction in the limits last year. Will the Minister reinstate the amount allocated for travel to work and home improvement loan entitlements for medical card holders? The former is required in particular where there is no public transport or very little provision. The withdrawal of the provision is most unfair. I urge the Minister to reintroduce such entitlements.

I welcome the commitment to community-based services such as home help and services for those with disabilities. I hope that what we see on paper will be evident on the ground in practice. I concur with other speakers on what has been said about mental health.

Chairman: I thank Deputy Healy. I will call on the Minister first and then Mr. O’Brien. Seven other members have indicated that they want to speak. I will take speakers in blocks of three. I urge speakers to be precise and concise as it would help the process.

Deputy James Reilly: I will endeavour to do my best. Deputy Kelleher raised the issue of a change in the wording of the service plan following the Cabinet meeting. First, I ask whether he takes as fact everything he reads in the newspapers. Much of it is not fact. What is factual is that the wording did change and the rationale behind the change was the fact that the Cabinet
committee was able to agree a revised Estimate volume and additional money which allowed for a change in the wording.

Another question Deputy Kelleher asked was how long it would take to identify where the €108 million comes from. I will invite Mr. O’Brien to say a bit more about it but it is something that will require time to study. It is within the Haddington Road agreement and must come from pay within that, but the mechanisms must be further evaluated.

Deputy Kelleher stated that the figure of 57,000 discretionary medical cards was a reduction compared to the previous number, but as we all know and as has been stated to the committee time and again, and elsewhere, there has been a huge increase in the number of full medical cards allocated. We are at the highest number ever and we have allocated a further €35 million this year for new medical cards.

The Deputy inquired about the White Paper on universal health insurance. I have it in draft form to a very high standard. It requires some minor adjustments in terms of further discussion and it will be published in the coming weeks.

Reference was also made to consultant-led clinical care. It was the policy of Deputy Kelleher’s Government - one that I would not necessarily dispute - that there be more consultant-delivered care rather than consultant-led care. The recruitment of consultants is no more difficult than it ever was. There are always certain areas and specialties where it is difficult to attract consultants.

Deputy Kelleher said mental health had been grossly underfunded. The Government committed €35 million last year and the previous year, and €20 million has been committed this year with a commitment to deliver a further €15 million next year in additional funding to mental health. I will not take any lectures from Deputy Kelleher on how we fund mental health.

**Deputy Billy Kelleher:** I am just stating a fact.

**Deputy James Reilly:** With Fianna Fáil’s record-----

**Chairman:** Could we have one speaker at a time, please?

**Deputy James Reilly:** We did not interrupt Deputy Kelleher, so perhaps he would be good enough to leave us to make our contribution uninterrupted.

Deputy Caoimhghín Ó Caoláin asked from where the €113 million figure for medical card probity had come. The figure provided was €133 million. A sum of €20 million was provided for in the original Health Service Executive plan and a study conducted some time ago by PwC identified the possibility of making savings of between €65 million and €210 million. We pointed out at the time that these estimates were highly speculative and indicative only. The figure of €113 million is somewhere close to the mid-point of the PwC estimate. That is the answer to the Deputy’s question.

I was asked when we could expect general practitioner care to be available for children aged under six years. It will be available somewhere in the middle of this year. Legislation is required, as is a new contract to reflect the new arrangements.

Deputy Caoimhghín Ó Caoláin has stated virtually nothing has been done on the issue of reference pricing. A substantial amount of work has been done on the issue and a considerable amount of money has been saved. There are many considerations involved, including the role
played by the Irish Medicines Board, Professor Michael Barry and others in achieving savings in the drugs bill. Mr. O’Brien and Mr. Hennessy will be able to address the matter in a much more detailed manner.

The Deputy referred to extraordinary waiting times under the fair deal scheme. The average waiting time is in the region of three weeks. The reductions in funding for the scheme are being used to provide more places for additional home care initiatives. This could result in upwards of 1,000 people being able to stay at home, rather than ending up in long-term care. We are, therefore, exchanging 700 long-term care places for approximately 1,100 additional packages that will enable people to stay at home. This approach makes financial sense and is much more sensible from the perspective of the client and system. People do not want to go into long-term care before they need to. If we can introduce new and innovative methods to help and support them to stay at home, we should take that route.

The Deputy referred to the Department making available funding for cochlear implants. This was a priority of mine and several members of the joint committee. I will ask Ms McGuinness to discuss the issue in detail.

I was asked also what was meant by the figure of €108 million in unspecified savings. I explained this matter, but Mr. O’Brien will discuss it in greater detail.

I am not sure what Deputy Séamus Healy meant when he described the budget as unsustainable for a third year in a row. In the past three years the number of people enduring long trolley waits has reduced by 34%. While there is always a blip at this time of year, members should bear in mind that three years ago this month 569 patients were lying on trolleys on a given day. Under the Government, the number of patients on trolleys has not come anywhere near that figure. The current figure is in the mid-300 range and in the first ten days of this month has reduced by approximately 10%. Ward Watch is a separate method of addressing additional spaces being taken up in hospitals. As the Ward Watch figure was not available to us last year, it is not possible to compare figures using that measure. One can, however, compare the number of patients on trolleys. We count the number of patients on trolleys in a hospital, rather than in the emergency department only.

Deputy Séamus Healy asked about the figure of €56 million for cost containment measures in hospitals. The officials from the HSE will deal with that issue in more detail. The Deputy also referred to savings of €7.5 million that are to be achieved through hospital reconfiguration. Obviously, savings can be made by having groups of hospitals working together in terms of how they organise their staff, etc.

The appointment of the boards of the hospital groups is imminent. I will leave the matter of agency costs to officials from the HSE. Deputy Séamus Healy correctly pointed out that he had raised this issue before Christmas.

It is true that the income limits applying to medical cards have remained unchanged since 2006. While one would have expected them to increase in 2007, 2008 and 2009, one would not have expected them to increase since, given the fall in inflation that has occurred. I should point out again that the number of medical cards is at its highest ever level.

I addressed the issue of mental health when I noted the additional funding and staff provided for this area which has been the Cinderella of the health service for many years. The Government has sought to address this matter and destigmatise mental health problems. For the first
time, the new primary care centres have mental health facilities. We aim to have patients removed from the old institutions and treated in the community and to have mental health issues dealt with in the same way as any other health issue is dealt with. For this reason, a new psychiatric unit is being built in Beaumont Hospital to accommodate patients’ needs and ensure they do not have to go to old institutions located at the end of peninsulas. These institutions would have been located out of sight and out of mind on islands if the authorities had afforded such an approach in those days. That it is the old way of addressing mental health issues. All members will agree with A Vision for Change, the strategy the Government is supporting and funding.

Mr. Tony O’Brien: I shall start by addressing the issue of the language used in the introduction to the service plan because much is being made of the issue. It is important, therefore, that I put the matter into context.

Until the Cabinet meeting in the relevant week in December, the level of deficit risk associated with the numbers in the service plan was unacceptably high. It derived from the €113 million figure for probity measures, which I made clear was not deliverable, and the figure of €108 million, in respect of which we do not yet know the method by which it will be deliverable. There is, therefore, a figure of well over €200 million in respect of risk. If it had been necessary to publish the service plan with that level of risk, it would have brought with it almost an inevitability and certainly a strong danger of a precipitative mid-year financial crisis this year. If there were to be such a crisis, the health service would be forced to take immediate corrective action, much as it has done in years past. Recent history demonstrates that this would leave the health service with very little room for manoeuvre and would likely create the conditions in which the only measures that could be taken would be those that would have a direct adverse impact on the level, quality and quantum of care provided for the most vulnerable in society. In that context, the version of the introduction prior to the relevant Cabinet decisions stated it would not be possible to meet “critical service priorities”. It did not refer to the possibility of meeting all of the demographic pressures. The words that have changed are not, therefore, the words the Deputy believes were changed. I deleted a reference to it not being possible to meet critical service priorities because I no longer believed there was that level of risk in the light of the changes made. Instead, the language members see in the service plan is consistent with what I have said previously and today at the committee. This section of the service plan carries my signature and consequently reflects my opinion on the overall position of the service plan. The words used previously in the plan were mine in the context of the risk there would have been without the key decisions made. The words used in the current plan are mine in the context of the actual service plan. I know there has been much reportage in one newspaper, but I share the Minister’s view. As we will see when we discuss the issue of reference pricing, there are distinct dangers in taking newspaper reports at face value.

I ask Ms McGuinness to comment on the issue of cochlear implants, after which I will address the other issues raised.

Ms Laverne McGuinness: On cochlear implants, a sum of €3.22 million has been provided in revenue funding and an additional €1 million has been provided in capital because there is a capital cost associated with the programme. The programme provides for two types of cochlear implant. The first is simultaneous, whereby children will have two cochlear implants placed at the same time. The second is sequential which will be provided for children who have one cochlear implant and would benefit from a second. In that vein, we met the consultants involved in the delivery of the programme. The figure provided is the maximum they will be able to spend this year. The programme will commence in May, with 50 children set to benefit from
simultaneous cochlear implants. Under this element of the programme, 100 cochlear implants will be provided. In addition, commencing in August, another 50 children will benefit from sequential cochlear implants. Commencing in August, another 50 children will benefit from sequential cochlear implants. There are approximately 300 children on the list to be assessed for these implants. It is the assessment of the consultants concerned that approximately 200 of these will progress, of whom 50 will commence on the programme from August onwards, with a further 150 to go forward for next year and the following years. That is the position on the cochlear implants programme. It will commence this year, with real progress starting in May.

Mr. Tony O’Brien: On the issue of the sum of €1 billion, it was actually at the last quarterly meeting of this committee that I used the phrase, which the record of the meeting will show, that the challenge was not cuts of €1 billion but a “swing” of €1 billion. I used that language very precisely and it referenced my understanding at that time of the likely underlying deficit - not the actual deficit in 2013 but the consequential deficit if all costs continued to run into 2014 - and the then figure of €666 million, which was the abridged Estimates volume figure. I have never said there were cuts of €1 billion. In order to avoid any misunderstanding, I left in the two figures, €619 million, as it was then, and €419 million, but I deleted the calculation of €1 billion because it was becoming apparent to me that it was becoming apparent to me that it was consistently being reported as “cuts” of €1 billion when it is not a cut but a swing. I have described in the budget strategy how we deal with some of that. There are not cuts of €1 billion. There is a swing of €1 billion. I used that language precisely but it has obviously not been universally understood. Therefore, I stopped referencing that €1 billion, but I left the two figures in. I stand over those two figures and my broad assessment of the requirement for a swing at the last quarterly meeting is borne out by the residual €619 million and €419 million. I hope that clarifies that matter.

With regard to the question about some of the things that will not be done in this service plan that otherwise might have been done, I will give the committee some examples. We would have liked to develop a national perinatal pathology service this year, at a cost of €420,000, but we are not in a position to do that. We would also have liked to go to phase two of our intermediate care service as part of the NAS, at an estimated cost of €4.4 million, but will not be doing that this year. The HSE would have liked to do more in the area of health and well-being initiatives, at an estimated cost of €1.5 million, but will not do so. We would also have liked to roll out an extension of BreastCheck, at a cost of another €0.5 million, in this current year but that is not proceeding. We also wanted to put considerable resources into revamping the dental treatment services scheme but we cannot do so this year. There is a list of things such as those I have just mentioned which, while being important developments, are not ones that can be afforded within the envelope that is available to us this year. Therefore, they stand as priorities that we will seek to address in the 2015 service plan.

It is important to stress, as many have done, that the cumulative effect has a significant impact on the health service and those who work in it. I thank the Chairman and Deputy Healy for their comments about the staff in our health services. I know others share their views in that regard. It is a key concern that during the course of this year we need to have a very robust process for identifying the needs of the health service if it is to meet the needs of our population.

On the issue of reference pricing, I will ask my colleague Mr. Hennessy to take the committee through what is involved, because the report referred to is very far from accurate, despite the fact that some of this information was provided to the relevant publication but did not find its way into the report.

Mr. John Hennessy: Reducing the cost of drugs and medicines is a major priority for us
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in this year’s service plan for the obvious reason that it allows us to reduce our costs while not impacting directly on front-line service delivery to patients. Quite a bit of work is already under way on this, led by Professor Michael Barry and Shaun Flanagan, our chief pharmacist. The recent newspaper coverage of this issue suggests that we have not been using the legislation to reduce costs and that we have not been moving quickly enough on this issue. The reality is that we have been moving as quickly as the Irish Medicines Board designates products as being interchangeable.

To further clarify the situation, the legislation that was passed in the Oireachtas last year requires the HSE to consider each product and medicine according to a number of criteria, of which six are listed. The HSE is further required to provide two blocks of 28 days, sequentially, for consultation and notification. The Irish Medicines Board designates groups as interchangeable on a sequential pattern. The first of those was atorvastatin, which was listed in September 2013, and we are now seeing the benefits of that in terms of reduced price. Others have followed in subsequent months. For example, four products of the ten listed were issued in mid-December 2013. We act on each of those as soon as they become available. We follow the consultation and notification due process procedures laid out in the legislation and the price reductions then follow sequentially. Indeed, a number are now primed to fall due in the very near future. Cost reductions obviously follow from that and the end result is very much on target in that we are going to realise €50 million of savings for the taxpayer in 2014 through reference pricing. Additional savings will be available to members of the public as prices fall in pharmacies.

It is important to note that a balance must be struck in this process so that supply is maintained in the pharmacies. That involves a process of continuous negotiation with the pharmaceutical industry and the suppliers. I wish to acknowledge again the work of Professor Barry and Shaun Flanagan. They are doing excellent work in this area and we look forward to briefing the committee during the course of 2014 on the progress being made.

Mr. Tony O’Brien: On the sum of €108 million and the issue of the critical changes, in order to step away from the figure of €113 million, we had a supplementary provision of €47 million. Our original internally generated figure for probity of €20 million moved to €23 million, which leaves €63 million unfunded as a result of the elimination of the €113 million element of the probity measures. In addition, we have €408 million. These are areas in respect of which there is an agreed process and it reduces the overall risk at the get-go from a health service perspective. On the question of the sum of €108 million, there will be no measures to support the €108 million which are not provided for in the Haddington Road agreement. The core Haddington Road target for this year, in terms of pay cuts, flexibility, additional hours and all of the other measures provided for under that agreement, is €140 million. What we are going to do is to seek to maximise the extent to which the flexibility provided by staff can be leveraged to reduce operating costs within the health system. There will be no other measures imposed on staff in the health service that are not provided for in the voluntarily agreed Haddington Road agreement. The process that we are going through will produce an outcome which will save some, all - or, conceivably, none - of that €108 million. We are optimistic that a good proportion of it can be produced. At the end of that process we will have a position in which, as the Minister has outlined, we can revert through a process that involves other Departments examining the implications of that. It is very important to stress - and I have sought to do so repeatedly - that we are not seeking from staff anything to which they are not already committed under the Haddington Road agreement. The issue is whether the Haddington Road processes can produce savings that are greater than €140 million, and the process we are going through will determine
that. I hope I have addressed all of the questions posed.

**Chairman:** I thank Mr. O’Brien. We have seven other speakers waiting so I will now call Senator van Turnhout, followed by Deputy Fitzpatrick and Senator-----

**Deputy Seamus Healy:** I asked a number of questions to which I have not received a reply.

**Chairman:** Okay. I ask the Deputy to list the unanswered questions, without elaboration.

**Deputy Seamus Healy:** I asked about agency costs.

**Chairman:** If the answers are not available now, the Deputy will be furnished with them as soon as possible. We can make that commitment.

**Deputy Seamus Healy:** What does the €56.5 million in containment costs refer to?

**Chairman:** One second, please, Deputy. Can Mr. O’Brien answer the question on agency costs?

**Mr. Tony O’Brien:** This is cost containment plans that were committed to by individual hospitals in the course of 2013 but where they have not yet delivered, so it is merely a continuation of obligations they put forward as a way they could reduce costs.

**Deputy Seamus Healy:** There is €7.5 million for hospital reconfiguration.

**Mr. Tony O’Brien:** That is a fourth quarter target and relates to leveraging the value of the hospital groups currently being put in place. It will involve leveraging the value that exists by putting hospitals together.

**Deputy Seamus Healy:** What does that mean?

**Mr. Tony O’Brien:** Hospitals could share many back-office and front-office services as a result of being amalgamated in terms of governance.

**Deputy Seamus Healy:** Back-office services?

**Mr. Tony O’Brien:** It will include back office but could include making better use of laboratory facilities, staff rosters and a whole variety of operational issues designed to improve the way hospitals use the resources provided to them.

**Deputy Seamus Healy:** Are they operational or back-office issues rather than relating to emergency or maternity departments for example?

**Mr. Tony O’Brien:** The €7.5 million is not contingent on that type of reconfiguration but we will examine that reconfiguration during the year.

**Deputy Seamus Healy:** What about the agency costs?

**Mr. Barry O’Brien:** I could give some guideline figures but in the interests of accuracy I would like to submit a separate report to the Deputy on that.

**Deputy Seamus Healy:** I asked for that before Christmas.

**Chairman:** I will deal with that. If Mr. Barry O’Brien can send that to the clerk to the committee we will ensure Deputy Healy gets it.
Senator Jillian van Turnhout: I welcome the witnesses and the news on bilateral cochlear implants, both sequential and simultaneous. Like Deputy Ó Caoláin, I hope it will continue and upscale in 2015 to meet all the demand because it is a set, limited group of children.

This committee has had a series of hearings on end-of-life care. It is laid out here in the service plan but we do not know what the budget will be because it is part of the acute services. Will it be the same budget or the increased budget of 2013, €72 million? At the end of page 32 one of the indicators is the total number of children in the care of the children’s outreach nursing services. It says there is a new performance indicator for 2013 but surely we should know what the figure is. Normally the indicator on 2013 figures is there, so maybe there is an error.

In terms of mental health services, we are in ground-hog day. In 2012, 2013 and now 2014 we are told the money is ring-fenced, yet we hear about the underspend and the demand for necessary services. One could say it is great news that we have 156 new staff in 2013 but from March 2009 to the end of 2013 we have 932 fewer staff working in mental health services. When will these new staff be allocated? Since I have been a Senator I have sat here and heard recruitment will begin in the next quarter but we never seem to catch up. The money is supposed to be ring-fenced. Where will the new staff be allocated? Will it be in CAMHS, adult mental health, old-age psychiatry or forensic psychiatry? Nobody ever seems to be able to give these detailed figures, which makes it very difficult for me to see when and where these staff will be recruited in mental health. We have 9,065 staff; A Vision for Change says we should have 12,240. On dual diagnosis, is the HSE considering integrating some services, such as mental health and addiction services? We see a cross-over.

Can the HSE confirm that no deficit will be transferred over to the Child and Family Agency? There seems to be a misunderstanding out there that as part of the budget, a deficit is transferred.

Chairman: We are discussing the service plan rather than the Child and Family Agency.

Senator Jillian van Turnhout: I know, but the budget for the Child and Family Agency is in the service plan. I am being very careful. I want to clarify it because people are saying a deficit will be transferred and I want to be clear.

Deputy Peter Fitzpatrick: I welcome the Minister, Deputy Reilly, and his staff, and the director general of the HSE, Mr. Tony O’Brien, and his staff. With an 8% increase in the population it is very important we maintain our front-line services and that the patients get the quality services they deserve. I welcome the news that 420,000 children will benefit from the new GP card for the under-5s. The Minister has stated it should come into operation in May. How much will it cost to introduce medical cards for these 420,000 children? I welcome the €35 million being provided for 60,000 medical cards. Does that mean an extra 60,000 medical cards will be issued in 2014? More than 90% of the over-70s are covered by either a medical card or a GP card. To qualify for that card, a single person is allowed to earn up to €500 per week, and a couple €900 per week. I met many elderly people over Christmas and they are very concerned about their medical cards. As the Minister stated earlier, with the number of over-65s increasing by one fifth, what is the long-term future of medical cards for the over-70s?

Will any disability services suffer in 2014? How many hours of personal assistance home support is being provided in 2014? What will be the differences between 2013 and 2014? Will respite services be reduced in 2014? The nursing home support scheme, which supports more than 22,000 people in long-term residential care, will reduce the number of people supported
in long-stay care by 700, but will support an additional 1,000 people to continue to live in their own homes. How will this be done and supported? The HSE provides home help and home care packages for 56,000 people at any one time. In 2012 and 2013, 10.3 million home help hours were provided. Will this change in 2014? Are any new posts in mental health services coming on stream? How many additional posts will be filled in 2014 with the additional €20 million in funding?

I welcome the bilateral cochlear implant decision. I thank Ms McGuinness for her comprehensive report. I am delighted to hear the two programmes will begin in May and August. Obesity is a major issue in this and every other country. I plead with the Minister and the director general of the HSE to help combat it. This will benefit everybody in the future.

**Senator Colm Burke:** I join colleagues in thanking the HSE staff, including the back-room staff, for all the work they have done over the last number of years and hopefully throughout 2014, and their dedication and commitment. I am concerned about the fair deal issue and step-down facilities from the point of view that the number of people over 65 is increasing all the time. We are talking about providing back-up support for an additional 1,000 people at home. However, there is a problem with the number of people, particularly elderly people, being discharged from hospital and readmitted within a six-week time period. There is no engagement between the nursing homes about providing step-down facilities. Will that be considered during 2014? There is a big difference between having someone in hospital and back in his or her own home. A step-down facility is an intermediate place where they can get the level of support they need while allowing time for the proper management structure to be put in place for them at home. Could that be clarified?

This morning I read a letter in a newspaper that indicated that the entire health service had closed down over the last 12 months. The performance indicators record 2.57 million attendances in outpatient departments in 2014. Outpatient attendance numbers for previous years are not in the report. I know they cannot be provided today but it would be helpful if the committee had these figures to see the changes.

I notice the figure for medical cards for 2014 is 1.875 million. I would like the figures for previous years because this seems to be stable, as no reduction is proposed for 2014, whereas the public perception is a little different. It is important that we get this information, which is not contained in the analysis, out there. It would be helpful if it was there.

**Deputy Mary Mitchell O’Connor:** I wish to thank all the medical staff who go to work and do their very best. We have had hearings with groups such as Happy New Ear with regard to bilateral cochlear implants and with Dr. Jim Egan on organ donation and transplantation in which they made pleas for money. People listen to what is said at committee meetings and are delighted. Both organisations contacted me over the Christmas holidays to say thank you.

I am disappointed about BreastCheck but Mr. O’Brien stated that it would be a priority for next year. For the 140,000 women who use the service every year, we would like to see it extended to the age of 65 from 69. I would like this to be a definite priority.

We had numerous hearings on palliative care before Christmas. Last year the budget was €72 million, but €1.3 billion is spent in an unplanned way on end-of-life care. Does the Minister have plans to co-ordinate this so the money is well spent?

We have a major budget for obesity, but Dr. Sinead Murphy from Temple Street hospital
came before the committee and told us there is no specific budget within this for childhood obesity. I will reference something which everybody here might examine after the meeting. An app is available through iTunes whereby nine year old girls can be helped by other children to go on a diet to make their bodies look better. We must take this seriously. If this is what is happening in social media it is unfair to children. There is a massive budget for obesity and I ask the Minister to take some of it and target it specifically at childhood obesity. Whatever courses work should be rolled out.

**Deputy James Reilly:** Senator van Turnhout raised the issue of palliative care, as did Deputy Mitchell O’Connor. A substantial budget is directed at it but it is true that much additional money is spent on end-of-life care. Most of us would like to see people being able to end their lives at home and, if not, at least in a hospice. Mr. Ian Carter, the director of acute hospitals, has taken an interest in this and has plans to address it. Mr. O’Brien will address this matter further.

Mr. O’Brien will discuss the issues the Senator raised with regard to children in care and mental health. Many psychiatric nurses retire at the age of 55, as they are entitled to do. This is younger than the average nurse retirement age, so more people have left the mental health services as a proportion of the number over all elements of the service. We have been playing catch-up. Through A Vision For Change there has been a need for a change in the type of person working in our health service. We have much more need for allied health care professionals such as psychologists and counsellors as well as nurses. We are moving away from the old model to the new model. An element of change in this regard is happening also.

The Senator asked whether child and family services will carry any deficit forward into the new agency. They certainly will bring their proportion of it because otherwise other elements, such as disability and the HSE, would have to take it. I do not mean Senator van Turnhout, but people have a tendency to ask for something to be ring-fenced. This means twice as much must come from what is left, so a 2% drop overall becomes a 4%, 5% or 6% drop in certain areas because other areas do not have to take any of the load. The Child and Family Agency is hugely important and is a big part of the commitment of the Government towards children. We want to see it fare well but we are not in a position to take the entire deficit. A proportional amount was left with the services and much was taken back by the HSE centrally.

Deputy Fitzpatrick spoke about the cost of the addition of children under six to the medical card scheme. A total of 240,000 additional children will be covered as a consequence of this initiative, at a cost of €37 million. He also mentioned medical cards. A total of 60,000 additional medical cards will be provided for. The long-term future for the medical card for those aged over 70 is universal health insurance. This is how it will be addressed, obviously not in this term of government but in the next, if we are re-elected by the people to carry through on the reforms on which we have made major progress and continue to do so.

I do not believe there has been a change in the number of home help hours from 2013 to 2014. I will ask Ms Laverne to address this question and that about respite services. A number of committee members raised the issue of the Fair Deal scheme. When people can see a large pot of money they tend to go for the resources. The consequence is that many people have ended up in long-term care before they needed to be there and without full and proper assessment. We are developing a single assessment tool which will be rolled out this year in 50% of cases and rolled out fully next year. This has taken quite a long time to develop and we must train all of the people involved who will use it. It is about transparency and fairness. It has not been fair in the past. In some parts of the country people went into long-term care long before they required it while in other parts people waited for long periods, long after they needed the
Several people raised the issue of obesity. We take it very seriously and as part of our Presidency of the Council of the European Union we debated it during the ministerial meeting which I and the Minister for Children and Youth Affairs, Deputy Fitzgerald, chaired. We have a special action group on obesity. It is a preventable cause of chronic illness and death and there is no doubt that if we do not address it we may very well be the first generation to bury the generation behind us. Consequent on the obesity epidemic will come a diabetes epidemic. When I started as a doctor one never saw a type II diabetic under the age of 30, but now we regularly see teenagers with type II diabetes, which is appalling. We need to address this. Dr. Stephanie O’Keeffe might say a few words on health and well-being. This is a cross-Government initiative and does not only involve health. It must also involve the Departments with responsibility for education, the environment, justice and finance, the latter with regard to VAT on certain products which are healthy, calorie-free or low in calories compared to others. We are the first Government to put in place at principal officer level in the Departments of Health, Children and Youth Affairs and Education and Skills an individual responsible for co-ordinating services and preventing childhood obesity.

Deputy Mitchell O’Connor mentioned organ transplants. I am pleased that we can put more money into the project, particularly rapidly developing live transplants. We all acknowledge that the procedure saves lives, leads to a better quality of life and saves a large amount of money.

Senator Colm Burke mentioned a step-down facility issue. I discussed the improvement in the number of intermittent care facilities as late as yesterday with Members in the Department. In the past an older, frail person would enter hospital suffering pneumonia that would be treated within 72 hours but unfortunately other problems would ensue. Therefore, a person would have to remain in bed for a prolonged period and end up having to go into long-term care. Had such that person received an aggressive programme of physiotherapy or occupational therapy from 48 hours onwards he or she may not have had to enter long-term care. We are examining the matter and are thinking outside of the box. We are considering some of the NAMA hotels which have en suite facilities, gymnasium, canteen facilities and, in some cases, swimming pools, as possible locations for a new type of intermittent care. We are considering more cost-effective methods and better solutions for patients. People want to retain their independence for as long as possible and, as a doctor and a politician, we should support that wish in every way we can.

**Chairman:** Has NAMA indicated a willingness to work with Government in that context?

**Deputy James Reilly:** It has, on numerous occasions, not just the buildings mentioned but also primary care centres that might be suitable. However, I shall not go into detail here as it would not be appropriate.

The Senator also asked for outpatient figures. We are waiting for a tiny bit of work to be done on the figures which will be done during the course of the week and then I will provide him with the figures. We are the first Government to collate the figures which amounted to 386,000 outpatients. As I said at the time, it was not the figure that astounded me but the fact that many thousands of people had to wait longer than four years to see a consultant after a GP referral. We said that we would try to get everybody seen within a year by the end of this year. However, we only got the figures in March. We said that we may not reach the target but would get as close to it as we could. I am given to understand that the figures will be very positive news. I do not have the figure at present so it would be wrong for me to discuss the matter.
We have already mentioned medical cards. The Senator also sought the medical card figures for this year, last year and the year before. We can get such information and will give it to the committee clerk who will forward it to members. That is all the matters that I can cover and I shall now hand over to Mr. Tony O’Brien.

Mr. Tony O’Brien: As regards mental health posts and the 414 new posts in the 2012 service plan, all bar a handful have been filled and they relate to areas of particular disciplinary shortage. With regard to the 477 posts in the 2013 plan, 180 posts remain in process and the vast bulk of them will be filled fairly quickly. Between 250 and 280 have been identified in the 2013 plan because the exact mix of posts will influence the numbers that can be afforded. We will shortly publish the operational plans by division and they will have more details on the matter.

Members were correct to say that staff shortages is one of the impacts that followed the various voluntary exit programmes implemented in the early days of the financial crisis. It was voluntary in the sense that one could put one’s hand up and avail of an incentivised early exit programme or a grace period exit. Many staff who left were from the very areas that we are prioritising for development. That is why the figures are what they are. We are playing catch-up, to some extent, in some of the areas. Unfortunately, there is no getting away from that fact that many of the staff were part of the more than 12,000 staff who left.

I shall ask my colleague, Ms McGuinness, to comment on the performance indicator. The palliative care budget will be centralised and led by a single national director, Mr. Ian Carter. He will be the national director for acute care. The choice was made because there is a need to move some palliative-type care out of acute settings and into appropriate palliative care settings. Giving one person control of the two budgets is considered to be a positive move. No budget will be at the same level in 2014 as it was at the opening point in 2013 due to the effects of the Haddington Road agreement and other equitable share-outs. There has been no specific real cut to the palliative care budget and there is no intention to go in that direction.

I shall ask Ms McGuinness to respond to Deputy Fitzpatrick’s questions on home care but I shall respond to the questions on outpatients. We have accelerated the pace of access for patients. Nonetheless, it is our intention, probably, to reduce the overall level of attendance. The change is due to a disproportionate number of repeat attendance versus first attendance. The matter was sought to be addressed in the cancer space as far back as Professor Keane’s time here when there was a never-ending cycle of repeat attendance and thus limited clinical value. We want to see a greater proportion of first attendance being part of the access programme. We do not want people pursued relentlessly with follow-up appointments that are beyond the point of clinical relevance.

Deputy Mitchell O’Connor asked a question on BreastCheck. As she may know, I was appointed director of BreastCheck at a certain point in my career and, with a heavy heart, it was left out of the service plan. It is something that we will seek to include again as soon as it is practicable to do so, not least because it is a priority in the programme for Government.

I ask my colleague, Dr. O’Keeffe, to comment on obesity which is a central part of the health and well-being agenda.

Dr. Stephanie O’Keeffe: A whole-of-government approach will give us a real opportunity to address a range of modifiable risk factors that have given rise to an increased prevalence of chronic diseases and an increase that we are set to see if we do not do something about them and
provide a joined-up Government approach. I am pleased to be working with the Department of Transport, Tourism and Sport and the Department of Health on developing a physical activity plan, examining what we are doing to increase physical activity, accelerating some of that work and injecting a scale and pace in the programme.

The reform programme provides a real opportunity to examine the creation of these new divisions with a view to trying to imbed preventive care in the work of the health service and ensuring that every contact counts. In that context, we will review community nursing services and dietetic services this year. We will do so in order to see what kind of capability is available to address these issues, specifically for children but not just children. One can see from the data published in the Growing Up in Ireland report that 26% of nine-year olds are overweight and-or obese and according to the new TILDA study, two out of three adults over the age of 50 show increasing levels of obesity.

As regards children, this year we will provide training to 2,000 GPs on the new ICGP weight management treatment algorithm. We will also role out a new pilot scheme of school-based growth monitoring sites. If the pilot scheme works then we will role it out nationally.

The work of the clinical strategy and programmes has provided a real opportunity to imbed preventive care and early detection into a range of clinical programmes comprising vascular diseases, COPD and asthma. The initiative would have a real impact.

Members may have noticed that the HSE has joined the Department of Health and safefood in a communications campaign to inform parents about the correct portion sizes for children. The campaign will also focus on sleep, physical activity and the consumption of fizzy and sugar sweetened drinks. A lot of information materials and online supports are available. So far the campaign has proved successful in terms of recognition levels and demand for materials.

There is a broad cross-sectoral element to the HSE’s work, particularly through health promotion and improvement. We work with sports partnerships, schools and a range of externally funded agencies to try to address physical activity, diet and nutrition across key target groups. One can see that the health and well-being division’s service plan lists a range of actions that aim to tighten our performance indicators so that we are in a better position to quantify activity and outcomes from initiatives. The data is very important and will allow us to build a larger prevention budget over time.

Ms Laverne McGuinness: With regard to children’s outreach nursing services for palliative care, it is a new performance indicator that will be routinely collected, validated and reported on a monthly basis for 2014 as part of a performance report. We have not carried out such work previously. I confirm to Deputy Peter Fitzpatrick that 1.3 million personal assistant hours were provided in 2013 and the same number will be provided in 2014. The number of home support hours provided for people with disabilities in 2013 was 2.4 million and the same number will be provided in 2014. That is in addition to the €14 million investment this year for disability services, €10 million for emergency placements, residential care and school leavers and €4 million for assessment of children under 18 years of age and autism services. Fifty-six thousand hours will be provided for home help in 2014, the same volume as in 2013. In addition, the €10.3 million budget allocation for 2013 will remain at the same level for 2014. Therefore, there has been no diminution in the level of service to be provided.

Chairman: Senator Burke indicated that a question had not been answered.
Senator Colm Burke: No. My question concerned the readmission of elderly people into hospital within a six-week time period and the need for step-down facilities. I do not think enough work is being done in that area and it needs to be looked at. There is also a need to engage nursing homes in that process.

Deputy Regina Doherty: I wish the witnesses a happy new year and the best of luck because this will be a challenging and difficult year.

My question is for Mr. Tony O’Brien. I am not trying to be picky. He talked about language when responding to other people about the known unknowns of the €108 million and the €80 million carryover from last year. It was €200 million that was unknown to him in the last plan that caused him to have anxieties about the risks associated with the plan, which were subsequently eased, allowing him to change the language in the new plan. I see €188 million in known unknowns here, which potentially puts this year’s plan at risk. I wish to ask a specific question about the two ring-fenced areas. These are pay-related savings targets. It is stated that they will not involve any additional payroll reductions outside of what is already in the Haddington Road agreement, aside from the €140 million targeted for Haddington Road and agreed by everybody, and no new measures will be introduced that are not already in the Haddington Road agreement. I am not sure I understand that. I hope it does not sound as though I am thick. A total of €140 million is coming from Haddington Road, and another €188 million is to come from Haddington Road also, but we do not know from where it will come. Who is in charge of that verification process? What is the scope of that verification process? Mr. O’Brien indicated earlier that a verification process might result in the money’s not being found. If that is the case, what happens to that €188 million at the end of this year? Is it the case that we just do not hit the target and we come back looking for more money?

With regard to the decrease in staff to 98,000 whole-time equivalents, how many people does that mean we will actively seek to make redundant this year? What changes will need to be made to practices in order that overall hours are reduced?

We have been talking about language. I wish to ask a question because I am really curious about something. In the opening paragraph of his statement, Mr. O’Brien mentioned the Mid-Staffordshire report, the Keogh report and the HIQA investigations into safety and clinical care at Galway University Hospital. That makes me nervous. Is he trying to say something else? Is he trying to say it will be difficult to provide a patient-led service this year given the budget constraints? He mentioned earlier that had the HSE gone ahead with the previous service plan he felt it would have caused immediate corrective actions to be sought during this fiscal year. Is Mr. O’Brien 100% sure that the fear he had has been alleviated, or does he still see that as being in play this year?

Senator John Crown: I welcome the Minister, the director general, Mr. Tony O’Brien, and the team, and wish them a happy new year. I know it will be a very challenging year for everybody working in the health service.

I welcome the focus on safety but it is important to realise that there is a lot of talk about this. I studied this formally when I studied health management and quality. With regard to the quality metrics that are used, clearly, for those who are on the front line, what is measured is compliance, not true quality. It is compliance with a predetermined standard. To be fair, the predetermined standard can be set as high or as low as those who are designing the standard wish it to be. I hate to personalise this, but in the Galway tragedy, for example, to me there is one key metric - which was mentioned, in truth, in the HIQA report - which is not irrelevant.
The part of Western Europe that has the smallest number of consultant obstetricians per head of population, no matter how much it complies with a predetermined guideline, is not going to be the safest place for obstetric care. That part was the HSE west region. It has the lowest number of consultant obstetricians per head of population of any part of western Europe and, to the best of my knowledge, the lowest of any part of the OECD, despite the fact that Ireland has one of the higher birth rates within the OECD.

Safety is very important. I have been at the cutting edge of all kinds of safety issues over a long career in medicine and in college, and I utterly understand the tragedies that can occur. However, safety is not only a matter of errors of commission; it also involves errors of omission. People who are on waiting lists - who are waiting to come into the system but who have not engaged with the system - will not appear in the safety metrics, but they are ones who, I believe, suffer the greatest level of departures from true safety in the Irish health system.

On an allied issue - I am sorry if I sound pernickety about this, and I do welcome any reduction in waiting lists - it is not really obvious when looking at hospitals that the waiting lists are shrinking that fast, although I hope they are. I would like some reassurance about the internal HSE documents we got our hands on during the year - which, interestingly, contained whole bits of boilerplate lifted from an NHS document. They suggested that a new strategy was being used for measuring when waiting lists began in the outpatient component of the HSE services. It was stated that referral letters would be sent to clinics on behalf of patients, at which time they would be told that they would be contacted when there was a slot for them. At that stage patients go on the waiting list. I will be glad to make the document available to the Minister. One may not actually be on the waiting list for some months after one’s GP has received the letter, which will have the effect of cosmetically appearing to abbreviate waiting lists which are, in fact, not shortening at all.

The question of health service reform, the money-follows-the-patient model, etc., do not represent this year’s budget plus reform. This year’s budget is having the trouble it is having because the system needs reforming. The system is full of perverse incentives and inefficient use of health care resources because of the way the system is funded and because of the silo-like nature of the different responsibilities. I have to be very careful how I say this because I do not want to get anybody into any sort of difficulty, but I can tell the committee that lots of patients in the public hospital system are put through very inefficient processes to obtain a test because it is realised that the outpatient wait for the test is so long as to be meaningless for the clinical history of their illness.

I wish to ask two very pointed questions. I notice that the projections for service numbers in the acute services are 2,000 down on those for 2013. Can I get the firm assurance of the Minister, the director general and their colleagues that these will come predominantly from administrative functions and not from front-line services? Can we get a commitment that we will end all public relations, all management consultancy contracts, all corporate affairs offices within the HSE until such time as the acute front-line needs of patients are being met? At that time we will be able to afford the luxury of public relations contracts, which, to be honest, do not exist to foster public relations but exist in a client-attorney relationship to advance the reputations of those who pay them.

**Deputy Ciara Conway:** I thank the Minister, the director general, Mr. Tony O’Brien, and his staff for making themselves available. There is no doubt that we are facing into a very difficult year for those who use the system and those who work within it. I join my colleagues in acknowledging the tremendous work carried out in primary care and in acute sectors through-
out the country. There are some positives and it would be remiss of us not to acknowledge that. We had extensive hearings on organ donation. Those services stagnated for a number of years and were limited in the kinds of life-changing operation that could be carried out. There are many people who are thankful for the increased funding that has been provided at a very difficult time. That is welcome.

I wish to focus on a report carried out about two years ago, whose name eludes me - I apologise for that - on the internal financial and auditing systems that were not in place within the HSE. At that time it identified that those working in a financial capacity within the HSE often had no financial or accounting qualifications. What is the position now in regard to upskilling those people? Have we recruited people with the correct skills base to do this?

I note in the report that €40 million has been allocated for ICT investment across the HSE. It promises to deliver quite a lot. I would like to know a little more about this. There are but a couple of lines devoted to this in the relevant report. The HSE hopes to implement recommendations on approved hospital clinical systems, the national patient administrative system in the south-east and mid-west regions, the development of a medical laboratory information system on hospital sites and the development of corporate systems, including the health insurance claims management system, a matter I have raised time and again. Also referred to is a single integrated financial system, about which I am particularly concerned. Am I right in saying the majority of the deficit pertains to acute services?

Mr. Tony O’Brien: Yes.

Deputy Ciara Conway: We find in the period approaching October and November that we are seeking to take money from other services. Despite this, we want to try to reduce delayed discharges from acute services by 10% this year. How will we meet the target of a mere 10% if we do not have a financial system that allows the primary care and mental health services to spend their budgets to prevent the acute services from continually seeking more? If we do not allow this expenditure, we will never be able to meet our targets in regard to delayed discharges.

Everybody, including the Minister, has said the cost of treating patients at home or in their community is less, by multiples, than the cost of treatment in an acute setting. I acknowledge it is not always straightforward, but if acute services are to continue to hoover up money, if inefficiency is rewarded time and again and if those who are efficient and meeting their targets are being punished, we will never be able to implement the reform that is so badly needed throughout the HSE and health care provision platform.

Deputy Sandra McLellan: I thank the delegates for their presentations.

If the target of €108 million cannot be realised, what will be the consequences and what services will be hit? With regard to access to assessments for young children with behavioural conditions such as autism or paranoia, waiting times are consistently in breach of those stipulated in the Disability Act. They can be from two to eight months. Is there a budgetary provision to address the waiting lists? In the mental health budget is there a provision to tackle the shortage of child psychiatrists? I know of cases where young children presenting with suicidal tendencies or who have attempted suicide are being seen only by social workers because there are no psychiatrists available.

Deputy James Reilly: Deputy Regina Doherty’s questions were aimed mainly at Mr. O’Brien and concerned reduced staff numbers and the figure of €174 million.
Senator John Crown talked about the low number of obstetricians. We must examine the model of care in this regard and whether pressure could be relieved in the delivery of babies of young mothers in hospitals if we looked outside the box a little more and supported midwife-led and delivered services.

Nobody present could possibly suggest the tragedy that occurred in Galway could be excused on the basis of staffing levels; there is no question about this. A basic point with which I am sure Senator John Crown will concur is that if a doctor orders a test, he or she does so because it will alter his or her management of the patient. One’s first duty of care must be to get the result of the test to see whether it will alter the management of the patient. I do not want to get into specifics in that regard. There have been three reports on the tragedy and, at this time of the year, our thoughts should be with Savita’s husband and family.

Let us consider the issue of patients awaiting access to outpatient services. I will certainly examine the contention that letters are left in limbo until there is a response given and that there is manipulation which would not be acceptable to me. I am not interested in perception but in reality. That is why we counted the number on the outpatients waiting list which no other Government wanted to touch. We want to address this issue in a realistic way and support those who work in the health service to do so. That is what is being done. It is on the basis of the same principle that we have used in providing inpatient treatment. Once the cancer and urgent cases have been dealt with, people who wait the longest should be seen first. Doing so is equitable and fair.

I believe Deputy Ciara Conway was alluding to the Ogden report, which we commissioned.

Deputy Ciara Conway: Yes.

Deputy James Reilly: As a consequence of that report, there was a further report. We now have in place Mr. Thomas Byrne, the chief financial officer. Within his remit, he has a complete reform board for financial reform within the HSE. We know there are 11 systems from the old health boards. Equally, we know there are literally hundreds of IT systems throughout the health service. Somebody mentioned a figure of 1,700 and some of the systems are not able to talk to each other. New ones are being developed and there are problems with their ability to deal with what needs to be put in place. I will allow Mr. Byrne to talk about that issue in a more complete fashion.

There is a sense among certain people that acute services drain all of the resources from everywhere else. That is not absolutely true by any means. The two areas with the greatest deficit - in nearly equal amounts – are demand-led and one concerns acute hospitals. If somebody presents who is acutely ill, it is not like the airline industry in that we cannot refuse to take off because the aeroplane is not safe; we have to look after the person or he or she will die. Equally, the PCRS is often in serious deficit because it is also demand-led. If people are entitled to and need a medical card, they must have it. There is no doubt that further efficiencies can and will be achieved, but they take time. Much of the low-hanging fruit has gone. I refer to the new ways of delivering care, the new models of care and the areas I have addressed before at the committee, including the questions of why we have nine nurses per health care assistant in some model four university-type hospitals and 2.8 nurses per health care assistant in others and why we have 2.5 health care assistants per nurse in some community nursing home units, while we can only manage a ratio of 1:1 in others. There has been a difficulty in achieving best practice across the system. We are now achieving this through the special delivery unit in the HSE and particularly through the clinical programmes which have carried out extraordinary
work in many places. An example is the care of stroke sufferers. The survival rate from stroke has shot up as a consequence of the clinical programmes. The same applies to the programmes dealing with congestive heart failure and frail elderly persons. More needs to be done and, as I mentioned, the single assessment tool must be borne in mind.

Deputy Sandra McLellan asked what would occur if the target of €108 million was not achieved. I will allow Mr. O’Brien to address that issue, but in my view the answer is very simple. The Department of Public Expenditure and Reform, the Department of the Taoiseach and the Department of Health, with the HSE, are examining how the target may be achieved. If it transpires that it is not achievable, it will become a matter for the Government to revisit. That is the straight, simple fact of the matter.

With regard to children, there is a new model of assessment and intervention in making progress on disability services for children and young people. Some €4 million has been put aside for that purpose and 80 whole-time equivalents. The area of children’s mental health services is a source of grave concern. Historically, it tended to fall between stools. In north Dublin, for instance, there was a considerable deficit in the services to provide for those between the ages of 16 and 18 years when the legal age of a child was raised from 16 to 18 years. A question arose as to where those in this category belonged in terms of the provision of services. All those issues are being ironed out. There is still much work to be done but I believe we have come a long way. Perhaps Mr. O’Brien would address specifically Deputy Regina Doherty’s questions.

Mr. Tony O’Brien: With regard to the €108 million and the €63 million, the €63 million is derived from a transfer of €63 million from our original pension provision in order to offset the gap between the Supplementary Estimate and the original target for medical card probity. The €108 million relates to the unspecified payroll savings. I will ask Mr. Barry O’Brien to come in on this and when we get to patient safety, I will ask Mr. Crowley to say a word, if that is all right.

If the €108 million saving is not achievable, it will not be capable to state that it is a failure of the Haddington Road agreement. The Haddington Road agreement has a certain design specification. It produces certain savings for us. For those earning in excess of €65,000 per annum, it produces straightforward banded pay cuts, which are easy to achieve and easy to bank. The other main savings come from flexibility, from extra hours which enable us to displace agency and overtime, and in services where there are no agency and overtime but the totality of the extra hours mean that there is more staff than needed, through the redeployment mechanisms available under the Haddington Road agreement and its predecessor, they enable us to reduce costs in other locations. We believe €140 million is within that design specification. We have not allocated our €80 million of that because of wanting to ensure that we allocate it to exactly the right places and do not ask some services to do what they cannot do and let others off the hook.

In relation to the €108 million, it is considered possible that the displacement of other cost in excess of €140 million could be deliverable to contribute to the €108 million. That does not ask more of our staff but asks more of our managers in the way they use the flexibility and the extra hours to displace cost.

I will ask Mr. Barry O’Brien to talk about the verification process, but, as the Minister has outlined, we will within the next period be completing the evaluation process that Barry will describe. If at the end of the evaluation process it is clear that some part of that €108 million is not deliverable and if it is clear that the pension provision will be underfunded as a result of the move of €63 million, there is a process available to us within Government to have those issues
addressed. There is no mandate to translate those issues into service cuts. The Haddington Road agreement is not about service cuts. It is about reducing the cost of services. That is an important point I should make. I will ask Barry to add something in terms of the process.

Mr. Barry O’Brien: The challenge for us in the HSE, both for the statutory and all of the funded agencies, is to maximise everything which we can under the Haddington Road agreement. As the director general, DG, has said, there are some fixed savings which are completely predictable - how much it will save over the year for the pay cut over €65,000, how much it will save by the adjustment downwards in the rate of overtime being paid, how much it will save by the absolute freeze on increments and how much it will save by the delayed payment of increments. The real variable comes in the main in the totality of how one manages the additional hours. If one takes, for example, that Government approved the recruitment outside of the employment ceiling of 1,000 graduate nurses and the recruitment of 1,000 support staff, those are additional to our existing cohort. We currently employ approximately 99,930 staff. We did not meet our employment control framework, ECF, target this year; we fell short by approximately 1,000. Therefore, there was a balance to be struck between delivering safe services and maintaining services and how we manage the employment ceiling.

Deputy Regina Doherty asked if we would be making staff redundant. There is an absolute guarantee that there will be no compulsory redundancies under the Haddington Road agreement on the proviso that staff give complete flexibility. However, if one takes it, for example, that under the Haddington Road agreement there are approximate 5 million additional hours in the system, how will we manage that? One needs to challenge the managers by asking they have done with their hours, whether they have redeployed and reassigned staff, changed rotas or come up with new ways of working. I suppose one is asking the managers, before they even contemplate having any service reduction, whether they have maximised use of the Haddington Road agreement. We are introducing immediately an assurance group which will introduce a standardised model to measure what is happening in each site as per the quantum of additional hours that was delivered under the Haddington Road agreement. This is not what could be; this is what is signed up to. To emphasise what the DG has stated, we will undertake that exercise. We will work with managers to state in that instances they could have done something else. For example, we had an incentivised career break earlier last year before the Haddington Road agreement was concluded for which we received 2,500 applicants; we were only able to facilitate 326 of those and we are now proposing to reopen that scheme. Therefore, one could have an orderly facilitation of staff who wish to take an incentivised career break where one then achieves pay savings by replacing those staff with staff on additional hours and replacing the direct skill set. All I am saying is that is the challenge now facing us and that is why there are no certainties until we get in there to see what is happening and maximise the enablers.

Mr. Tony O’Brien: I will deal now with the issue of what is stated in the service plan on the broad issue of patient safety and, lastly, will deal with the issue of finance, and I will bring Mr. Thomas Byrne-----

Chairman: Mr. Tony O’Brien might mention the capital plan as well.

Deputy James Reilly: That is not for today. This is the service plan, not the capital plan.

Chairman: I understand that but it is also contained within the service plan. I asked a specific question regarding a date for the capital plan.

Deputy James Reilly: I do not yet have a date for the committee but it will be in the com-
Chairman: I thank the Minister.

Mr. Tony O’Brien: The reason we have focused so heavily on patient safety in the opening section of the report is not because I have specific fears, as the committee would be concerned, but because at a time when the public discourse about the health service is always about the money, it is important that those leading it send a clear signal that the health service must be about patients and patient safety. That is the primary reason it is there. In addition, there has been in this part of the world - by which I include these islands - a significant period in terms of learning from adverse incidents, both in this jurisdiction and in the neighbouring jurisdiction, and we thought it was absolutely appropriate to put that front and centre in the opening paragraphs of the chapter. We absolutely accept, in response to Senator Crown, that merely saying it does not do it but over time the debate about the health service, internally and externally, has been overly focused on money, deficits, etc. That is heard by managers and staff up and down the country and they need to hear from ourselves, reflecting the message of the Minister, that the most important matter is the quality and safety of our services in all respects, including those who are struggling to access them at present. If I may, I will ask Mr. Crowley to add to what I have said.

Mr. Philip Crowley: I agree with Senator Crown in so far as one must set a series of targets. Targets, as one will be aware, and as we have seen their impact on other jurisdictions, can lead to game-playing - somebody referred to a possible example of that this evening already - and can lead to tunnel vision.

What is important about the service plan is, first, that it has a clear emphasis on quality and patient safety, not only when services go wrong. It is about improving the quality of care and, really, in the end of the day, is measured by patient experience. The committee will note in the appendix that there is an increasing number of measures of quality being assessed during the year. We also will be working with the system to develop what we are calling a “quality profile”, which is a set of validated measures of quality, but also incorporating matters such as what incidents have occurred in the setting for which one is responsible, what has one learned from them and what has one done about those incidents. It will include validated measures of patient experience and, hopefully, with time, also staff experience because we believe that front-line staff have much to tell us about the quality of care that we provide. We believe we should be listening to front-line staff more and that we would have a much higher quality service if we do that more effectively than we currently do.

To reiterate the point about the Mid-Staffordshire report and the Keogh report that followed it, it is imperative that we learn from other jurisdictions. We share our learning with other jurisdictions as well. There are lessons from those reports for us. I have brought that report on two occasions to the management team for us to reflect on those reports and to ensure that we put in place safeguards to ensure that such level of care does not happen in our system.

Mr. Tony O’Brien: I emphasise there always is a danger, when one has someone who is identified as the director of quality and patient safety, that it could be perceived, either internally or externally, that it is that person. If one looks at every divisional section of the service plan, quality and patient or client safety, as the case may be, are referenced and very clear. Those national directors who are not present today will be at our quarterly meetings - there are too many to bring all at once - but they all accept a focus on patient safety as a fundamental part of their obligations. It is not just saying it but doing it and making it a key part of every decision made,
recognising that opportunities to improve arrive from time to time and that there are decisions which, if one goes the wrong way, will have an adverse impact on patient safety.

To turn to the issue of the staff reduction, where we have a say, we will not be facilitating the exit of staff from front-line services, not least because we would need to replace them and would simply be increasing our costs were we to so do. That said, there is a grace period exit programme envisaged in the Haddington Road agreement to August 2014 and we will have no control over who chooses to exit early to avail of enhanced or preserved pension entitlements. We cannot control this, but where there are voluntary schemes, they will be voluntary on our side also. Unlike in the past, while there will be no compulsion on a person to go, a person who volunteers to go will be faced with a manager who will be obliged to volunteer to let him or her go. We will not be seeking to let people go where we need to replace them. In the last year we did not achieve the targeted reduction. In some instances, that was because we would not let people go because patient safety could have been compromised. Consequently, in so far as there is a hierarchy, achieving a reduction in people is not at the top of it because it does not always make sense to so do. We must make calls and take responsibility for them. Notwithstanding the fact that we are required to balance a range of Government policies and priorities, we must and do make calls.

I am deliberately taking the financial control space last because in some respects, it is part of the message we are trying to send. I refer to the Ogden review and the follow-on report I commissioned on becoming the acting or deputy chief executive officer of the HSE, namely, the PA Consulting Group recommendation. Moreover, the financial improvement programme approved by a board which I chaired and which included senior personnel from the HSE and the Departments of Public Expenditure and Reform and Health is now available on the HSE’s website. It spells out in absolute detail the manner in which we intend to reshape the financial management model, that is, moving away from an excessive concentration on financial transaction processing to more of an added-value financial management process to ensure funds are properly tracked and used etc. As the Minister stated, the appointment of the chief financial officer is part of that process and I will invite him to say a word. I acknowledge that a specific question has been tabled in this regard for the quarterly meeting and the answers have been supplied in respect of the numbers of staff and so on. However, we seek to reform fundamentally the way we approach financial management in the system. We are, by agreement, developing a business case for a single common chart of accounts, supported by a single financial system, which will apply to the whole of the publicly provided health service. This will, among other things, help us to address some of the issues being addressed by another committee of the Oireachtas because of the visibility it will give us.

In respect of acute services, last year, in the 2013 plan, we carried out a significant rebalancing in respect of additional resources. It is true that the overall cost of providing the acute system has come down considerably. However, at a certain point in time we had reached a stage where the health service was guaranteed to be destabilised by financial overruns in acute services because, put simply, too much had been taken out too quickly, more than anywhere has ever successfully achieved. It was creating a situation where, when I became the deputy chief executive officer of the HSE in August 2012, I was faced with a likely overrun, without significant corrective action, of €500 million. That led us in a highly negative direction in terms of some of the cuts that had to be made and it is to avoid precisely this, that these processes I have described around the figures of €113 million, €108 million and so on are so essential. Without such processes, the level of risk attached to the service plan would have been sufficient that I would not have changed the introduction, to put it in a nut shell.
Mr. Thomas Byrne: To follow on the comments of Mr. O’Brien, he has covered the salient points in respect of what is happening. I mentioned previously that I was appointed to this role six months ago. It is important to state, however, that although the Comptroller and Auditor General’s report states annually that the systems in place are not fit for the purpose for which they are intended, at the same time there is a rigorous audit carried out every year and, touch wood, we have had a clean audit every year. The issue arises from the number of finance staff, that is, approximately 60% of them, who spent their time working on systems that are not fit for purpose, not on front-line work or driving the business forward. That is what we intend to address. As for appointments, the question posed in that regard will be answered on Thursday. I think we have provided the information.

Chairman: No, members have not received that information yet.

Mr. Thomas Byrne: There are 122 qualified staff, but on my appointment, I was given the ability to hire additional staff. Following a detailed review around the country of what I had found, while some people outside were suggesting I would be obliged to bring in people around me at the top to sort out the problem, I did not. The people who are there are well able and more than capable of doing the job. Consequently, the people we are bringing in are younger accountants at a level below to free up the expertise to work with me in helping to drive this. These are the people with the expertise who can understand it and deliver it. I acknowledge that it is tricky and in a forum such as this, it is always difficult to start talking about changing financial systems. While we are preparing the business case for submission, with 30 years in the private sector and having worked on common operating models with BT also, I acknowledge that it is and will be difficult. However, there is a simple solution - if one keeps it straightforward and simple - one truth, if we are all using the same common chart of accounts to deliver information. Much work has been done on this already, on which we can work and that is my main priority in this regard. I believe that is sufficient on this issue.

Mr. Tony O’Brien: There was a final question from Senator John Crown on the use of consultants. We use consultants fairly judiciously, given the scope of activity with which the health service is charged, which is much broader than sometimes is understood by the term “health service”. It includes, for example, significant mass communications campaigns in the health and well-being space such as the one that is running. I should pay tribute to Mr. Gerry Collins who has cancer and volunteered to assist us in that campaign. We use professional communications expertise to help us to put together the most effective public communications programmes. Similarly, we use PA Consulting Group in putting together the financial reform programmes. We are judicious in their use, but we need to have recourse to them at times when it is appropriate to do so.

Chairman: I call Deputy Caoimhghín Ó Caoláin briefly. Senator Jillian van Turnhout has also indicated that she had one question.

Deputy Caoimhghín Ó Caoláin: Initially, I had asked the question how it was that the HSE expected to be able to deliver a high quality service, while also seeing the departure of a further 2,600 whole-time equivalent, WTE, posts in the course of this year. As for Mr. O’Brien’s reply, I am not in any dispute with it, would welcome it and do not wish to see any of it achieved. However, it is another figure which is contained in the service plan. It is an intention that is part of the overall calculation. I think “arithmetic” is a word the Minister has used previously. Where does Mr. O’Brien expect these to occur since 2,600 WTE posts will be found? In his view, is this achievable at all? Is it desirable? So much of the service plan is a wish list; there is no certainty and it states “this may” or “that might...”. Ultimately, the joint committee’s con-
cern is that patient safety be a central tenet at all times and that people be able to access critical services on the basis of need, which is not always the case. I refer to Mr. O’Brien’s own line in terms of the change in the service plan and which uniquely, of all the other sentences delivered in his opening statement, stands, namely, “During the course of this service plan, it will not be possible to fully meet all of the growing demands being placed on the health service.” This is something to which we all must face up and accept. Somehow, somewhere, the change must come. These cuts are not sustainable.

Senator Jillian van Turnhout: I want to return to the issue of the Child and Family Agency and the deficit. The reason I may have looked puzzled when the Minister was replying to the question was that we sat in this room on 19 December with the Minister for Children and Youth Affairs and I specifically asked her to confirm the agency would not be burdened with a deficit from the start. She said: “The 2014 allocation will have to do solely with 2014 expenditure and will not have to address a historic deficit.” How can we reconcile the two statements? Will the Minister return on Thursday and explain whether there will be a deficit for the agency and, if so, how much? Everybody knows a new agency faces additional start-up costs. The agency is not being given a fighting chance and I would see it as a retrograde step if it is burdened with a deficit.

Chairman: Perhaps Mr. O’Brien will also make reference to the national ambulance service in his response, in the context of recent reports about the service and safety. We will take the response from the Minister now.

Deputy James Reilly: Mr. O’Brien will address the issue raised by Senator van Turnhout.

Mr. Tony O’Brien: In regard to the children and family service, as it was in 2013, I am and remain the Accounting Officer for that period. There is no carry forward of the services deficit from 2013 into the agency. However, there is a carry forward in respect of the HSE component - its full budget from 2013, plus some additions we made, particularly in the area of legal costs, and the full budgets of the other component parts. Whether there will be a deficit, however, depends entirely on how much money the agency spends in 2014. However, to the extent that part of the HSE deficit in 2013 was made up of children and family services, none of that deficit from 2013 carries forward as a first charge on to 2014.

Senator Jillian van Turnhout: None of that will be transferred. That is not what I heard earlier.

Mr. Tony O’Brien: The agency gets its full budget, but its full budget is not the same as its full expenditure in 2013, because it spent over its budget.

Senator Jillian van Turnhout: I may have to probe this further on Thursday, because I am a little confused.

Mr. Tony O’Brien: The Senator seems to have invited me to comment on the merits of the target for the reduction of staff in the health sector, which is a Government policy decision, but I am precluded from doing so. I would remind her of what I said earlier. Leaving aside exits by virtue of retirement, including those that may be stimulated by the grace period under the Haddington Road agreement, which only concerns people paid in excess of €65,000 and who are likely to have a pension in excess of €32,000 who have a financial incentive to go by August - a relatively small slice of the organisation - where there are voluntary exit programmes, we will not permit front-line key staff who would have to be replaced to leave under those schemes.
Consequently, there is a significant risk that the 2,600 figure mentioned may not be achieved. We also seek to employ significant additional staff in other areas. Therefore, the net number required to leave to balance this is somewhat higher.

I have said clearly that we will not seek to do or permit to be done things that have a direct, adverse consequence either on patient safety or which will increase our overall costs. One of the reasons we felt it reasonable to take funds from the pension pot was because we do not see that number of staff leaving naturally through attrition. I hope this is a reasonable answer to the question.

Chairman: Does the Minister wish to make a final remark?

Deputy James Reilly: I thank the Chairman and committee members for their time. We will be back in another 48 hours and can answer any questions left unanswered then. Hopefully, we will address Senator van Turnhout’s concerns further then.

Patient safety is the first and foremost concern in regard to all of this. For a long time, I have talked about focusing on better outcomes for patients and on seeing more patients more quickly. I would like to echo what the director general of the HSE has said. In the past, we have heard the same refrain day in and day out. I would have been part of that then. We had too much talk and focus on how many doctors and nurses there were and on how much money and how many billion euro were being spent. While more money would be welcome, if money alone was the solution, we would not be where we are now. The question I must ask therefore is why, after more than quadrupling health expenditure by 2008 from the early 1990s, we faced such a crisis in 2009 in emergency departments that the then Minister, Mary Harney, wanted to have the situation treated as a national emergency.

Money is not the key issue here, although it is important. Reform is the key issue, reform of how we work, how we deliver services, how we interrelate and who does which job. Too many silos have grown up and there are too many people who do not want to let go of what they are doing, despite the fact they complain they are overwhelmed with work. There is also a lack of transparency. The waiting list initiative, in terms of outpatients, is a classic and critical issue in terms of transparency and letting people see what we have and the situation with which we must deal.

I want to go further and will go further this year in regard to transparency. The waiting times for each department and consultant will be made available, initially internally but ultimately publicly. Morbidity and mortality rates will also be made available. Patients have a right to know what kind of doctor they are attending and GPs have a right to know the kind of doctor to whom they are referring patients. The empowered patient is a safe patient. Why would a patient not have the right to know that a visit to doctor X will mean a six-month waiting list, but a visit to doctor Y would only involve a two-month wait, particularly when both are equally qualified consultants? Let patients make that choice.

This year, we will continue to bring in legislation that will continue necessary reforms. We want to roll out the continuation of the “money follows the patient” model, to create purchase or provider lists, have functioning hospital groups and new integrated service areas, set up a new contract for GPs for children under six and present a White Paper on universal health insurance to allow a broad consultation with all interest groups to determine its precise shape. No doubt, this committee will have a huge input into that.
I will finish by thanking everybody who works in our health service, who have kept the service running and delivering care 24 hours a day, seven days a week and 52 weeks a year with fewer staff and money and in the face of increasing demand, as evidenced by an 8% growth in the population since 2006 and 20,000 more people over the age of 65 every year, which while great to see creates extra demand. While the staff of the health service have been doing all of this, they have continued to reform the system to provide better outcomes for more patients. I look forward to working with them and with this committee to continue these reforms over the next 12 months and to improve health services, which is our duty.

Chairman: Does Mr. O’Brien wish to add a comment?

Mr. Tony O’Brien: Should I comment on the ambulance service?

Chairman: We can deal with that on Thursday. I thank the members of the HSE and the Department of Health. It is important that we, as public representatives, acknowledge that the officials are here and are available to us, the committee and those with whom they work. I thank them for being here. I remind members that our quarterly meeting is on Thursday.

The joint committee adjourned at 7.30 p.m. until 9.30 a.m. on Thursday, 16 January 2014.