DÁIL ÉIREANN

COISTE SPEISIALTA UM FHREAGRA AR COVID-19

SPECIAL COMMITTEE ON COVID-19 RESPONSE

Dé Máirt, 2 Meitheamh 2020

Tuesday, 2 June 2020

Tháinig an Comhchoiste le chéile ag 11 a.m.

The Joint Committee met at 11 a.m.

Comhaltaí a bhí i láthair/Members present:

Teachtaí Dála/Deputies	
Richard Boyd Barrett,*	
Colm Brophy,	
Colm Burke,	
Mary Butler,	
Jennifer Carroll MacNeill,	
Matt Carthy,	
Michael Collins,	
David Cullinane,	
Pearse Doherty,	
Stephen Donnelly,	
Norma Foley,	
John McGuinness,	
Paul Murphy,*	
Malcolm Noonan,*	
Joe O'Brien,*	
Cian O'Callaghan,+	
Fergus O'Dowd,	
Louise O'Reilly,	
Darren O'Rourke,+	
Marc Ó Cathasaigh,*	
Matt Shanahan,	
Róisín Shortall,	
Duncan Smith,	
Peadar Tóibín.+	

* In éagmais/In the absence of Deputies Bríd Smith and Ossian Smyth.

+ In éagmais le haghaidh cuid den choiste/In the absence for part of the meeting of Deputies David Cullinane, Matt Shanahan and Róisín Shortall.

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

Business of Special Committee

Chairman: Today Deputy Joe O'Brien will substitute for Deputy Ossian Smyth and Deputy Tóibín will substitute for Deputy Shanahan. Are the minutes of 19 and 26 May agreed? The minutes are agreed. A letter from Construction Industry Federation was sent under correspondence. I take it that the 36 items of correspondence are received and noted. Members will have received submissions for today's meeting.

Deputy David Cullinane: While we are dealing with correspondence, I sent a letter on behalf of the Sinn Féin group on a matter we also raised at our procedures meeting. We feel it is important that we have a follow-on session on private nursing homes with the HSE and the Department of Health. We would like that to happen as quickly as possible, but we want that noted.

The revised work programme which was circulated includes modules on childcare. As the economy will start to reopen again in phases, it is important that we deal with childcare.

We have had some very good discussions here on private nursing homes. Nursing Homes Ireland was here and it is only fair that we bring back Mr. Paul Reid and Mr. Jim Breslin on those issues at the earliest opportunity.

Deputy Fergus O'Dowd: It is very important that we bring in the private nursing home sector. I have many questions that I wish to ask them further to our earlier discussion.

Deputy Mary Butler: I support Deputy Cullinane's first point. Many questions that I asked last Tuesday were not answered yet *The Irish Times* had the answers on Thursday. That is extremely disappointing. We must revisit that and ask why we, as a committee, cannot be given answers on a Tuesday yet they appear in *The Irish Times* on a Thursday. It really undermines our role.

Chairman: I completely agree. That was raised by several members. A letter will go to the witnesses who came before the committee to ask them to explain the discrepancy between the answers we received and what was put in the public domain. However, we need to give them time to answer that before we bring them in again.

Deputy David Cullinane: Has that letter been sent?

Chairman: It was sent today. We had agreed it Thursday morning. Obviously, yesterday was a bank holiday.

Deputy Colm Burke: That also applies to HIQA. We requested information that should have been made available to us after the meeting, which the witnesses knew very well we would have been looking for.

Chairman: All of those bodies will be given an opportunity to explain the discrepancy. There may well be an explanation. I will not prejudge that.

Deputy John McGuinness: In the previous two sessions we asked a number of questions; and members used their time just to ask questions. We were promised written responses to those questions. Some of the questions were relevant to this morning's session and we have not

got those answers. Within what timeframe do we expect the replies to come? It is a bit unfair that we are trying to do our work here and the questions that we have already asked have not been answered and now we are going into a session this morning on private hospitals and we still have not got the answers that were asked weeks ago. I do not think it is unreasonable that we should-----

Chairman: No, but part of the difficulty is that we have not had a lead-in time. We established the committee and we went straight into meetings without having the usual lead-in time for a committee. I think we cannot overburden agencies and institutions, but at the same time we do need answers within a timeframe. Ten working days was set out in the letter. For any letters that were sent after the first meeting the ten working days will only expire tomorrow.

Deputy John McGuinness: It is not acceptable that the media would have the answers to questions that were asked here within the ten working days, yet the same person who might have released that information to the media has not made it available to us. It shows a disrespect to the House and the work of the committee.

Chairman: I have no idea who released information to the media or who put what into the public domain but I agree with Deputy McGuinness on the general principle and a letter is being sent to that effect today. We are looking for an explanation. Members will be free to follow up when they come back in on any explanation given for the fact that information which we had requested was put into the public domain.

I will call Deputy Boyd Barrett and then we will move on. I am not trying to stymie debate; we can go into private session, but we have witnesses outside that I think we need to hear from.

Deputy Richard Boyd Barrett: The Government announced that it would make changes to the public-private contract on Friday.

Chairman: It did.

Deputy Richard Boyd Barrett: I immediately contacted the secretariat in writing and stated that in my opinion it would be crazy for us to have a session today with the HSE and the Department of Health without having the Minister, Deputy Harris, here as well because Mr. Breslin has already made clear that he cannot answer certain questions to do with policy because they are not in his remit. It renders redundant our sessions today if the Government has already made a decision. I believe the Minister should come in here today and explain what he is doing. Otherwise, what is the point of the afternoon session? I wrote on Friday and I phoned the secretariat but I do not know if the request has been processed.

Chairman: Deputy Boyd Barrett's request was conveyed to the Department of Health. It was made clear that the Minister, Deputy Harris, could come in to answer questions and that Deputy Boyd Barrett specifically believed that it was more appropriate for him to answer the questions. The Minister has not availed of that opportunity to come in. Deputy Boyd Barrett and other members may regret that but, be that as it may, I do not necessarily accept the point that the session is rendered redundant. While the private hospitals are subject to the deal, there is a question mark over exactly what procedures will be carried out in those hospitals for the entire month of June, as a backlog appears to develop in the health system and in a variety of elective and non-acute treatments.

Deputy Richard Boyd Barrett: I will not labour the point as we need to get on with business but this is closing the door after the horse has bolted. The Government has made a major

announcement that it is going to change the deal and hand back much of the private capacity without us discussing the extent to which we need that private capacity, whether it is the best way, if we should be going back to the two-tier system or if, as some of us believe, we should be going forward to a national public health system. This is pre-empting all of that and our oversight becomes meaningless.

Chairman: Rather than tell me, Deputy Boyd Barrett will have an opportunity during the week to tell the Minister that in the Dáil session, and also to ask him why he felt it inappropriate to come before the committee. Perhaps they are questions that can be asked but there is no point in asking me when the Deputy will have an opportunity to ask the Minister directly during the week.

Deputy Fergus O'Dowd: On a point of clarification, notwithstanding everything Deputy Boyd Barrett has said, the Taoiseach and Minister for Health offered to come before the first meeting of the committee. The total transparency of all of their actions is reflected in their willingness to come here. It was the committee which turned down the opportunity to bring in the Taoiseach and Minister. I did not get a copy of the request that the Minister attend today. The Minister is not afraid to appear here. He offered to do so *ab initio*. I just wanted to make that point.

Deputy Róisín Shortall: On that point, it would have been helpful to have received a briefing from the Department setting out the details of ending the deal and the arrangement in place.

On another point about today's session, which is very strange, is that we are discussing the deal with the private hospitals without representatives of the Private Hospitals Association. Special interest groups, namely, the consultants, are to appear. I cannot understand why the consultants are coming in but the association with which the deal was done is not appearing. When we deal later with the issue of travel restrictions, we will not have workers from Aer Lingus or the Dublin Airport Authority here to plead their case. An inconsistent approach is being taken.

Chairman: We are limited to two-hour sessions. A normal committee meeting could last for four hours and we could bring in different witnesses and rotate them. We simply do not have that capability. As to whether we have the right or wrong witnesses, the working group at its meeting next Thursday can firm up in advance who we are bringing in to be absolutely certain that we have-----

Deputy Róisín Shortall: The deal is with the Private Hospitals Association, not the consultants.

Chairman: Officials from the Department of Health will appear. I presume they will be able to answer members' questions. If we continue in this fashion, however, the witnesses who are seated outside will be unable to answer questions.

Deputy Colm Burke: I agree with Deputy Shortall on this point. The Department made the deal with the private hospitals. They should be part of our discussions and should appear at some stage.

Chairman: Procurement is a matter for the State. The Department officials will be here and I hope they will be able to answer questions. At our working group next Thursday, we can decide who will appear in the two subsequent weeks and achieve as great a degree of consensus as possible. However, the time available is limited and the more time we spend discussing this

matter, the less time we will have to hear from the witnesses we have invited who have taken the time to come here.

Deputy David Cullinane: To be helpful, I propose that on Friday the Committee on Procedure consider having an additional schedule on private hospitals. As part of that, we could invite representatives of the private hospitals and the Minister for Health if members believe that is what we need to do. We should now proceed with this morning's session. If there is agreement on my proposal, the Committee on Procedure could consider allowing a session with additional witnesses in the next couple of weeks.

Chairman: Time permitting because, as members will know, we hope to discuss a raft of issues, including healthcare, childcare and the reopening of the economy. Unfortunately, we are more constrained by time than committees typically are.

We have discussed the work schedule. Following the meeting of the committee's working group last Friday, members have been circulated with a draft programme to 23 June. We will seek to have a fourth session each week on Thursday mornings starting at 9.30 a.m., which is before the Dáil sits.

Deputy Róisín Shortall: Where is the Thursday session taking place?

Chairman: I will confirm that at the end of this evening's session.

Use of Private Hospitals

Chairman: We are joined in the Chamber by Mr. Martin Varley, secretary general of the Irish Hospital Consultants Association, IHCA, and Mr. Maurice Neligan, consultant orthopaedic surgeon. From committee room 1 we are joined by Professor Alan Irvine, consultant dermatologist, IHCA, and from the Irish Medical Organisation, IMO, by Ms Susan Clyne, CEO, Dr. Anthony O'Connor, and Dr. Matthew Sadlier. Can we be heard in committee room 1? Yes.

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

Members are reminded of the provisions in Standing Order 186 that the committee should also refrain from inquiring into the merits of a policy or policies of the Government or a Minister of the Government or the merits of the objectives of such policies. We expect witnesses to answer questions asked by the committee clearly and with candour. Nevertheless, witnesses should expect to be treated fairly and with respect and consideration at all times and if they have a concern in that regard, I invite them to raises that concern immediately. I remind members that witnesses should be treated in accordance with the witness protocol.

I ask, finally, that all witnesses confine their opening statements to five minutes - these have been circulated in advance. We are under very tight time constraints. I ask Mr. Varley for his

opening statement.

Mr. Martin Varley: Good morning, Chairman and committee members. I will read through the statement as quickly as possible.

I thank the committee for the invitation to join in its discussions on the use of private hospital capacity and the impact of the agreement on the continuity of care and healthcare delivery.

The IHCA is the representative body for more than 3,200 hospital consultants practising in public and independent hospitals. The association represents approximately 95% of all hospital consultants in Ireland. This submission outlines our views at the time of writing on Friday morning, prior to the outcome on the Cabinet discussions on the private hospital agreement, which was scheduled to take place during the day.

The association's members have been front and centre in treating Covid-19 infected patients throughout our acute hospitals since early March, in addition to providing emergency, trauma and urgent care to patients with non-COVID illnesses. This includes consultants in essentially all specialties across the full spectrum of acute hospital care. Whole-time private practice, WTPP, consultants have demonstrated their commitment by continuing to treat patients with urgent care needs on a voluntary basis in private hospitals throughout Ireland in the absence of a suitable contract and in the face of other significant constraints. We have sought agreement on practical and workable contractual arrangements that would properly enable WTPPs in treating Covid-19 and non-Covid-19 patients while also continuing to treat their existing and new patients who rely on them for urgent medical and surgical care.

This includes patients across all ages and demographics from the 46% of the population that has maintained health insurance over the years. For a relatively high proportion it includes older people who have maintained health insurance at all costs, going without in other aspects of their life, so that they could afford timely care when needed. This is driven by the access problems that exist in our public health service, a problem which has been caused by the failure of successive Governments to ensure adequate capacity in our public hospitals. This is not the fault of any patient, but it is patients who are now being penalised because of the failings in our health service.

Independent hospitals carry out 250,000 theatre procedures annually, accounting for approximately 40% of the total number of procedures requiring anaesthesia in acute hospitals. Those figures relate to 2015 and I expect that today the figures are even higher. Consultants in private practice also provide care for medical patients and are responsible for a significant proportion of outpatient consultations.

The IHCA working group engaged with HSE and Department of Health officials in early March and over the past two months on contractual proposals to be offered to WTPPs to enable the provision of care to patients in private hospitals and consultant outpatient clinics. The proposals of health service management are preventing and restricting whole-time private practice consultants providing continuity of care to their patients. The contract being offered does not provide for the practical workable approach required to facilitate the optimum engagement of the maximum number of WTPPs. This is despite months of constructive efforts and collaborative engagement with officials by the IHCA working group. This has resulted in large numbers of existing and new patients of private practice consultants being deprived of the continuity of care they urgently require. The failure to resolve these matters is seriously impacting on the provision of care to patients across private hospitals and in private consultant outpatient clinics.

As a consequence, large numbers of patients requiring urgent care are being added to waiting lists unnecessarily. In addition, it is adversely impacting on the effective use of private hospitals and the clinic capacity of WTPPs.

In March, on a precautionary basis, the State entered into arrangements to have access to the private hospital capacity to cater for the expected steep surge of infected patients requiring acute hospital care along the lines of the experience of Lombardy and Madrid. The steep surge did not occur because of the mitigating actions taken and at this time it appears it is unlikely to occur in the months ahead given the success of the public health measures implemented thus far. The test of time has confirmed that the private hospital agreement, which is costing approximately €115 million per month, represents poor value for money from patient care and taxpayer perspectives. The experience is that of very low private hospital bed capacity occupancy, at approximately one third on average, and low utilisation of theatre and other ancillary facilities. Furthermore, the private hospital contract is prohibiting the provision of urgent care required by patients with non-Covid illnesses. This is leading to the accumulation on waiting lists of a large number of patients who require urgent care. There is now the additional risk that these patients will deteriorate clinically and will increasingly evolve into emergency cases if they are not treated without delay.

I will conclude with one or two final comments. We are basically calling for the contract to be brought to an end. I know decisions to that effect were taken last Friday. The most important thing is to utilise the savings that will be achieved through ending the contract to put in place increased capacity for our public hospitals. The Government and Dáil have already decided that there should be significant investment in additional acute hospital beds and step-down beds. This is provided for in the national development plan. We would certainly welcome these additional beds being put in place in an accelerated manner in the context of the current crisis.

Ms Susan Clyne: I thank the committee for the invitation. In light of the Government announcement that the current agreement with private hospitals will not be renewed, we would like to focus on the urgent measures required to enable our public health services to deliver care for both Covid and non-Covid patients. It is important that we remember our hospitals have been overwhelmed and operating at dangerous levels of capacity for many years and Covid has exposed the underlying fragility of our services. It is untenable that we continue with historic deficits in manpower and bed capacity in the context of increasing waiting lists.

We would like to begin with our recommendations. The HSE is due to publish its clinical roadmap for the reopening of services shortly. This roadmap must allow for a gradual reopening of both public and private care in tandem, prioritising patients based on clinical need. An urgent assessment of current capacity and how that capacity will be affected as we deliver care under new social distancing arrangements and infection control guidelines is needed. Given that the current agreement with the private hospitals will not be renewed, Government must support immediate investment through temporary builds while investing at the same time in long-term projects such as stand-alone public hospitals for elective care. There must be immediate investment to recruit and retain doctors to work in the health service, including targeted measures to address our unprecedented number of consultant vacancies, which now stands at more than 500. Successive reports and studies have demonstrated that the two-tier consultant pay issue is a major barrier to recruitment. We must appropriately resource diagnostic, radiology and laboratory departments to allow timely access to investigations for both hospital doctors and GPs in the community. We also need clear referral pathways for all patients into secondary care.

At the forefront of this national effort to deal with Covid-19, and notwithstanding the long-standing contractual issues and inequities, doctors across the health system have stepped up, working long hours in their normal work locations and being redeployed to other sites to deliver specialist care. Many doctors have worked without leave since the pandemic began. We should acknowledge in particular our non-consultant hospital doctors, NCHDs, who have been at the front line of care for Covid-19 patients, and our public health specialists who play an invaluable role in health protection and who should be awarded consultant status in line with the recommendations of Dr. Gabriel Scally. Fortunately, due to measures taken by the public, we have so far avoided the worst-case scenarios. It is very likely, however, that low numbers of the population have been infected and we are not yet out of danger. Until we have effective treatment options and a vaccine, we face continued uncertainty as to the impact of a second and subsequent waves, particularly as respiratory illnesses begin to circulate again as early as September.

Due to neglect by successive Governments our health system has huge deficits in bed capacity and manpower. Ireland has one of the lowest number of public hospital beds per population and our hospitals operate on average at 97% occupancy. Some 5,000 additional beds will be required to meet future demand and with more than 500 vacant posts, Ireland has one of the lowest number of consultant specialists in the EU. An additional 1,600 consultants are required to provide a consultant-delivered service.

Due to the cancellation of all non-urgent care across the public and private systems, 570,000 people are on public waiting lists for an outpatient appointment and a further 230,000 people are on a waiting list for inpatient or day-case procedures. Cancer screening programmes have been put on hold and GP access to diagnostics and referral pathways for all patients effectively have been closed down. The HSE and its staff now face significant challenges as it seeks to reopen services for elective, outpatients and other programmes. In this context we must ensure sufficient spare capacity for current needs and for a future surge. We will need to reconfigure the physical space and hygiene practices in our hospital facilities to maintain infection control to protect patients and staff. The rate of infection in healthcare staff is a matter of extreme concern. There will be an inherent reduction in capacity in our public services of up to 50% when new measures are put in place for delivering care in safe settings.

We know from our persistent lengthy public waiting lists that long delays in accessing diagnostics and specialist care can impact negatively on patient outcomes. Often the only way to access care is through the emergency department. As we emerge from lockdown and into a new normal, we simply cannot revert to a situation where additional beds are being added to wards and hundreds of patients are boarded on trolleys. Overcrowded waiting rooms at outpatient clinics cannot be a feature in our health services.

The Irish Medical Organisation, IMO, has repeatedly called for investment in acute bed capacity and manpower, but successive Governments have failed to provide the necessary resources. Instead of investing in additional beds and staff Government policy has been to purchase capacity from the private sector through the National Treatment Purchase Fund, NTPF. The NTPF, which was originally a short-term solution, has become a long-term measure thus depriving the public system of investment and enabling the continued neglect of our health services. A policy that consistently diverts funding to the NTPF in the absence of funding for our public health services will not address the problems of capacity and will not be a long-term solution to waiting lists.

While the agreement was the correct measure to take at the time, we must now recognise the need for urgent investment in our public health system and not revert to continuing the all-year

crises that beset our services prior to Covid-19. We appeal to the committee and the incoming Government to put health first in terms of sustained investment and to value those front-line workers with meaningful support to enable them to deliver care.

Chairman: I thank Ms Clyne. Before moving on I remind members that we have only five minutes per person, or a maximum of ten minutes if using another member's time. The order will be Sinn Féin, Fine Gael and then Fianna Fáil. Will Deputy O'Reilly be taking five or ten minutes?

Deputy Louise O'Reilly: I will take ten minutes.

I thank our witnesses and their members, and all our healthcare workers who do a phenomenal job day in and day out. We have said many times that while it is very nice to get a round of applause in this House at 8 p.m. on a Thursday, it would be even nicer to have the decent pay and conditions, and the equipment needed to do their job. That must be our focus. The appreciation is there but it needs to have very serious follow-up. I thank the witnesses for their statements. I suppose it is fair to say that we came into the pandemic in very poor condition in terms of our health service, not just in the length of our waiting lists but also in the level of overcrowding which existed. Into that breach stepped healthcare workers who proved themselves capable of changing their own work practices and adapting to the new environment in a way that was breathtaking. The IMO makes the correct point that in the deal that was done, the capacity was made very necessary due to the neglect by successive Governments over many years, as the IMO statement put it. We know why we were in that condition. That said, there was a very real and pressing need for the additional capacity to be sought. I want to concentrate on the value-for-money element of this deal of €115 million a month for a minimum of three months. Is it likely in the opinion of our witnesses that the private hospitals would have seen a huge downturn in business because of Covid-19 in any event? I do not think there is any question that the private hospitals were going to be full. The evidence suggests that people were staying away from hospital, that they did not want to be putting themselves in harm's way. We were purchasing from the private hospitals on the basis of the capacity that we needed, but we never achieved that capacity in the private hospitals and those beds were never utilised. Could the witnesses comment on what the likely activity would have been in the private hospital sector? Would it have experienced a similar fall-off in attendances for procedures? I hesitate to use the word "business."

Mr. Martin Varley: I will make an initial comment in response and will hand over to Mr. Maurice Neligan. He works in a private hospital as a private practice consultant. The first point about value is extremely relevant in a number of respects. I would link back to the Deputy's comment about ensuring we can recruit and retain an adequate number of hospital consultants in our public hospitals. It is a long-standing issue which the current Government has looked at. One fifth of our permanent posts are vacant and have been for some time. This Government commissioned a Public Service Pay Commission report on the matter, which recommended in September 2018 that parity should be restored to ensure we can recruit and retain staff. In fact, some of our figures suggest that we could do that on a cost-neutral basis. However, if we have savings arising now, a small part of those savings will go a long way to rectifying the recruitment and retention problem among our younger hospital consultants, who are very much front and centre in dealing with the crisis.

Going on to the Deputy's main point, value for money in the contract is obviously in question. We would regard it as being poor value for money with the passage time. Of course, when the deal was being agreed and struck initially, we would all agree based on what we were seeing

playing out in Italy and Spain, that we absolutely had to bring on board any capacity we had in the country. Our members practising in private hospitals were fully committed to that. As a working group, we invested a great many hours with the officials to that effect. With the passage of time, we can now see that we did not need the capacity. We must also allow for the fact that the population who depend on private practice consultants for care, often in their outpatient clinic and often requiring follow-on care in hospitals, would have returned to those hospitals in greater numbers than we have seen. We have lost the opportunity to use the capacity at a vital time and we have paid dearly for that. I would now like to hand over to Mr. Neligan.

Deputy Louise O'Reilly: I thank Mr. Varley for his input. Unfortunately we are on a really tight schedule. Mr. Varley can see the clock; we have five minutes left. If I could bring in a speaker from the IMO, I have other questions I want to ask.

Mr. Martin Varley: Sure.

Ms Susan Clyne: Across the system, both public and private, attendance has dropped off. Appeals were made from emergency departments, GPs, consultants in various specialties and the Irish Cancer Society for patients to come back. Patients were not coming in.

In terms of value for money, had we had the surge and had we required those ICU beds and ventilation spaces, we would not be querying the value for money. The decision had to be made. It is only now, as we move out of that time and phase from having the surge, that we can see what value for money could have been delivered in the context of the agreement with the private hospitals. We had not been able to test that.

Deputy Louise O'Reilly: I take that point but given that value for money has to be a factor - maybe not the only factor - it was necessary to get the capacity. As for a plan, we knew that the capacity was in case the surge happened. Was there a plan B? In the event the surge did not happen, was there a plan to ensure we would get some value for money out of those beds? Was there ever a plan B by the HSE, the Department of Health or the Minister that Ms Clyne is aware of?

Ms Susan Clyne: No, the consultant representative bodies were not involved in the discussions with the hospital associations to take over the capacity. I anticipate that the HSE will now want to use that capacity for elective care.

Deputy Louise O'Reilly: That time, however, has been lost. The surge did not happen and we paid for the beds, but there was never a plan to utilise them in the event that the surge did not happen.

Ms Susan Clyne: No, but in fairness, and it is different throughout the country, many oncology services were moved into the private hospitals. My colleague, Dr. Anthony O'Connor, might comment further on this. Endoscopy services were carried out in the private facilities. Work was ongoing, but it was stepping up and we did not get to the phase where it had stepped up.

Deputy Louise O'Reilly: It had not stepped up, according to our information, to beyond a maximum of 50% capacity in some instances, which does not-----

Ms Susan Clyne: I think that is across the system.

Deputy Louise O'Reilly: -----represent good value for money in anyone's mind.

On the waiting lists, which were described as running at 800,000 cases, what is the likely impact of this deal on them? Will we see higher numbers and longer waits in the post-Covid environment? I will put that to Mr. Varley before Ms Clyne, if she does not mind.

Mr. Martin Varley: For two very significant reasons, we will see higher waiting lists. First and foremost, the impact of providing care to Covid-infected patients has changed the situation in hospitals, and we saw the drop-off we have referred to in both public and private. That will give rise to very significant increases in the public waiting lists, but in addition, we now have hidden waiting lists in private hospital settings that we would never have had before. Some of them are urgent non-Covid cases, such as cardiac cases, oncology cases and ophthalmic cases - the list goes on. We have not been flexible, agile or innovative enough in dealing with this agreement to allow us to treat more patients. We have seen a great deal of flexibility coming from consultants throughout our acute hospitals to cater with the surge and everything that has given rise to, but we have not seen flexibility in terms of this contract.

We wrote to the Minister, having dialogued with the officials over a lengthy period, suggesting there were ways to introduce a more practical, flexible contract arrangement that would have optimised the use of the private hospitals' capacity and of the outpatient clinics, which were effectively shut. Consultants in private practices had a Hobson's choice. They either signed a type A contract that stated everything had to be public, which meant they could not feasibly maintain their outpatient clinic for thousands of patients-----

Deputy Louise O'Reilly: I am sorry to cut across Mr. Varley but that was the point I was making. There was no plan B-----

Mr. Martin Varley: There was no plan B.

Deputy Louise O'Reilly: In the event that the capacity was not needed for the surge, there was no plan B. No attempt was made to get some value for money, however small it would have been, from the additional capacity. It was based on making preparation for a surge but there was no plan B in the event that the surge did not happen.

Mr. Martin Varley: Regrettably, that is correct. Despite much effort at engagement on our behalf and that of our consultants, that was not reciprocated-----

Deputy Louise O'Reilly: There are only a few moments remaining so I will turn to Ms Clyne. On the issue of waiting lists, what will be the likely impact of this?

Ms Susan Clyne: Dr. O'Connor will answer that.

Dr. Anthony O'Connor: We started with 700,000 people on the waiting lists for hospital care. By the time we get back to work, we will be dealing with at least six months' pent-up demand and less capacity to deal with it than ever before. We have heard a great deal about patients being locked out of care in recent weeks, but what has not been stressed enough is that public patients have been completely locked out of care and are likely to remain so for the foreseeable future. We need to see a roadmap by which that care can open as soon as possible for everybody, not just for private patients but for public patients too. We have been told for the past three months that we are in it together and to hold firm. We cannot continue to lock public patients out of the service any longer. We need a good and robust plan for how we are going to get public outpatient and inpatient services up and running.

Deputy Louise O'Reilly: That should include the utilisation of the last month left of this

contract and for as long as we are paying for it to have some sort of impact, meaningful or even small, on the waiting lists.

Dr. Anthony O'Connor: I agree.

Deputy Jennifer Carroll MacNeill: I thank the witnesses for their attendance. We agree there was a need for additional capacity but at the end of March and the beginning of April, attendance was low and people were not turning up for many different reasons. The contract will not be extended beyond June. What can we do now to use June well to maximum capacity?

Dr. Anthony O'Connor: Utilising the pathways already there is one point. I do much of my elective endoscopy work now in a private hospital with which we partnered. That can certainly improve the day case waiting lists.

There is also the potential of an inpatient surge. Our members and many of my colleagues have reported certain resistance when trying to transfer patients from public hospitals to private hospitals. That needs to be worked on a bit better because there are patients who we in the public hospitals would have felt should have gone across but they met with barriers. That has to be looked into. If we get a surge of any activity, Covid or otherwise, in our emergency departments and we are back to having 70 to 80 people on trolleys at night, then we need to have that pressure valve and utilise it for June.

Deputy Jennifer Carroll MacNeill: Mr. Varley commented on the State taking over on a precautionary basis. He stated that this was an essential measure at that time. The passage of time, of course, gives us a different perspective. Does Mr. Varley's organisation agree that we are going to need to maintain some additional capacity in the medium term?

Mr. Martin Varley: There are important issues to be assessed in the context of what capacity we will need to provide for a potential second wave or a surge. We also need to allow for the fact that the patients who have not been in a position to get follow-on care from their private hospital consultants are actually catered for. There is the wider issue of waiting lists in general.

The primary lesson I have learned from this particular exercise is that we need engagement on a tripartite basis. We need engagement with health service management, the private hospital associations and the private practice consultants. It is difficult actually to design the most effective way to do something if one does not engage with all three in a round-table setting. That was the big failure. Looking back on it, we can see why and the rush that did not happen. However, as we go forward, it is hugely important that there is tripartite engagement to optimise the use of our capacity in our public and in our private hospitals.

Deputy Jennifer Carroll MacNeill: It is hard to disagree with that but Mr. Varley's organisation is open to the fact that there is going to be a need for ongoing capacity and flexibility from that side.

Mr. Martin Varley: There is. We need to be always available to provide surge capacity if there is a second wave. Indeed, we must optimise thereafter in order that we do not have the capacity to be underutilised as we have experienced over the past two months.

Deputy Jennifer Carroll MacNeill: That was for several different reasons, however. That was not just about a contract or otherwise. That was about the rate of presentations as well as everything else.

Mr. Martin Varley: Yes. There is always a danger it will continue because inflexibility in contracts and arrangements can actually be the devil in the detail. We have observed that with our whole-time private practice consultants, who are more than willing to look after Covid and non-Covid patients. In fact, a large number of them actually did so on a *pro bono* basis until the bank holiday weekend in May when the provision for clinical indemnity for them in that respect was removed. That was extremely surprising for consultants who wanted to look after patients.

Deputy Jennifer Carroll MacNeill: That was clarified fairly quickly, however.

Mr. Martin Varley: It took a week or two to reverse it. We have never really found out why it happened. It was quite bizarre in the extreme.

Deputy Jennifer Carroll MacNeill: Mr. Maurice Neligan has been operating within this system. Will he give the committee a flavour by way of example of the sort of work that has moved between the hospitals?

Mr. Maurice Neligan: I have worked in both public and private sector as a consultant in Tallaght for eight years before I moved into whole-time private practice. I have a view of the positives and the negatives of both sides.

The hospitals did work very well and stepped up, especially in my experience at the Beacon Hospital. In the Beacon Hospital, we had consultants who moved over from St. James's and Tallaght hospitals to provide non-urgent Covid care to cancer patients. My colleague, Dr. John Reynolds, did many oesophagectomies and Dr. Terry Boyle brought a lot of public cancer patients over to deal with significant breast cancer issues. That seemed to work very well. That was the majority of the work going on within the hospital. I spoke to both consultants and they said it was a very good operation for them. I cannot speak on behalf of the private hospitals.

Deputy Jennifer Carroll MacNeill: Of course.

Mr. Maurice Neligan: I completely agree with Mr. Varley that the real failure here was the inability to have the three groups, the three legs of the stool - the Government, the consultants and hospitals - in one room. It might have been a little more fluid if that had been the case.

Deputy Jennifer Carroll MacNeill: There is certainly an opportunity to do that for the next phase. I thank Mr. Neligan.

Chairman: We shall move to Fianna Fáil.

Deputy John McGuinness: Last week, I asked a question about the various samples that were taken and we were told that if someone did not sign the contract A documents, samples would not be processed. What was the fallout from that?

Mr. Martin Varley: The fallout was very significant. It put consultants in an invidious position. If a consultant was providing care to his or her patients and could not sign the contract because rooms facilities were not provided for, he or she found that the consultant pathologist in a particular laboratory to whom samples were sent in good faith was being told the specimens could not be reported on. We could have been talking about cancer specimens. It left both sets of consultants in an extremely difficult position. It got rectified after a week or so but we had similar circumstances, as I said, with *pro bono*-----

Deputy John McGuinness: How many patients were affected by that decision?

Mr. Martin Varley: Unfortunately, I do not have that detail but there could be a significant number, allowing for the fact that approximately half of the private practice consultants had not signed a contract. I am not in a position to guesstimate but it could be significant.

Deputy John McGuinness: Who issued that instruction?

Mr. Martin Varley: To my understanding, the instructions in relation to indemnity cover by the State and the State Claims Agency were being issued by the State Claims Agency on the advices of the health service management. It was, therefore, a joint effort to provide the cover for indemnity. I do not know who exactly took the decision. Obviously, the State Claims Agency issued it but I expect it did so after consultation.

Deputy John McGuinness: Consultation with whom?

Mr. Martin Varley: It would have to be the health service management. That would include, in my view, the departmental officials, HSE officials and, potentially, individuals at ministerial level.

Deputy John McGuinness: In reaching an agreement regarding the private hospitals, did the Department of Health or HSE take into consideration the debt that was being serviced arising from consultants investing in the services they were delivering? Was that question ever dealt with in the context of these negotiations?

Mr. Martin Varley: We had raised it quite early on in the discussions; I would say in or around the early days in April when it became clear to us that the type of contract being offered was type A only. If a less costly contract had been offered, the cost of rooms would not have been an issue. However, when it became quite clear nothing was going to be offered other than type A, we raised the issue of rooms costs. We put it to the health service management that certain specific cost headings should be agreed as being eligible. We did not get definitive agreement even on specific cost headings. Following on from that, we got commitments that further engagement, involving the national director of finance and an independent accountancy firm, would arise to work on that on the following Monday. I have had no communications in the interim despite seeking engagement to agree the broad headings. Even today, I am not aware of any private practice consultant who has signed the contract who has had his or her significant rooms outpatient costs covered.

Deputy John McGuinness: Does Mr. Varley believe that is an issue that has to be addressed? Is it an outstanding issue as far as consultants are concerned? Will they approach the HSE or the Department to find a resolution and compensation?

Mr. Martin Varley: It is an issue on which we have had some commitments, which will be addressed. However, the detail has never been progressed, to the extent that, following a meeting with the Minister and his senior officials in the first week in May, we sought such commitments and a number of our consultants emailed their costs in a very transparent manner to the senior officials in the Department to ask them to confirm if these costs are eligible, and they have not had any response in the affirmative or otherwise. The general response has been that the CEOs of the private hospitals should now address these issues but I am led to believe that the CEOs of private hospitals are encountering similar difficulties to those that we have encountered in trying to get agreement on even the cost headings and the particular costs.

Deputy John McGuinness: With regard to cancellations of procedures or ongoing treatment and care of patients, what does the waiting list look like now? How many were cancelled?

How many are likely to now form a new queue to receive the care that they were getting from a private consultant?

Mr. Martin Varley: It is difficult to estimate. Two or three things are happening at the same time. Some consultants would have seen their patients on a *pro bono* basis in their rooms but could not refer them and guarantee continuity of care. There is an aspect of care not being followed through. There is no doubt also about the aspect that some outpatient clinics could not continue in the uncertain environment that exists *vis-à-vis* covering costs and keeping clinics going at the normal rate. I am not on the front line so unfortunately I do not have all that detail.

Deputy John McGuinness: Has Mr. Varley any idea about cancellations? Is there a way to establish the number of cancellations across the hospitals?

Mr. Martin Varley: There is but one would have to survey consultants individually. I was trying to guesstimate the total number of outpatient clinic appointments where outpatients would be seen in private practice consultants' rooms. Even if one allowed for 33 patients to be seen in a week across two clinics, in two half days, there could be in excess of 1 million such outpatient appointments per year. I am guesstimating that 20,000 outpatient clinic appointments would normally take place in a week but it could be a lot higher. I do not know how many of those are lost.

Deputy John McGuinness: Some consultants have complained to members of the committee that in the context of that new arrangement, where private hospitals were taken in charge by the HSE, the output was very low because there was no working arrangement. Instead of covering a number of patients, as with the figures Mr. Varley has just given us, they were not able to do that number. As a result, there was little value for money.

Mr. Martin Varley: Yes. There were other contributory factors. For example, we sought a lot of clarity about indemnity. Clinical indemnity is multifactorial and multidimensional. A private practice consultant has clinical indemnity for outpatient consulting rooms and for the private hospital. It is only in the last week or two that we have had absolute clarity that a private practice consultant who has signed the contract is also indemnified for treating public patients in his or her outpatient clinic. As I referred to earlier, many variables were not discussed or provided for. We flagged those quite early. The frustration that private practice consultants had was that we were not getting answers, decisions or practical approaches.

Deputy John McGuinness: As many as 1 million patients suffered from this.

Mr. Martin Varley: This is the real problem. Many patients have suffered and care has unfortunately been delayed.

Deputy Marc Ó Cathasaigh: I am deputising at short notice for our health spokesperson, Deputy Ossian Smyth. I apologise if there is crossover with previous questions and answers. My first question relates to the transfer of patients for consultants who did not sign the new contract. Was a mechanism in place for those patients to be transferred onto the public list? If so, and if that has happened, is there a mechanism to deal with those patients now that the deal is coming to an end?

Mr. Martin Varley: It is a valid question. I am not aware of a mechanism, other than a general indication that patients can be transferred to a public list. I have spoken to many consultants who wanted to know how to go about this and transfer a large number of patients to a public list. Where do they go on that list? The aspect of continuity of care gets fractured once

we start talking about transferring a cardiac or cancer care patient, for example, in the middle of care, or when a person has an event and needs to be looked after. It does not make sense to transfer somebody in a critical stage of care into a public system that is already overwhelmed with very long waiting lists. This has been a major problem for private practice consultants. Many of them have said to me they have ethical and medical responsibilities to their patients that they could not ignore.

Deputy Marc Ó Cathasaigh: How many cases might we be talking about in this kind of scenario? Mr. Varley has indicated there is no existing mechanism to deal with that movement if it happened.

Mr. Martin Varley: There has never been a mechanism to deal with that as the two systems operated quite well independently with some integration. There was not a mechanism to that effect. We must also allow for the fact that in a crisis, the time and management availability to deal with this was quite limited. I am not saying this is an excuse for not doing it but the reality is it did not need to be done if a practical arrangement was put in place for WTPPs to look after their patients. That was quite feasible and doable in the circumstances.

Deputy Marc Ó Cathasaigh: The Government states the deal is ending but in the eventuality of another surge, as we know is extremely likely, it is likely private hospitals might be needed again to provide capacity. How has the engagement of the organisation been with the Department of Health on the matter? Does the witness have recommendations, although we should be more prepared now than we were? Are provisions in place in the event of another surge so we can continue the general operation of services like BreastCheck, for example? We should not be surprised in the same way if there is a resurgence of the coronavirus. Has a system been put in place whereby normal services like BreastCheck can be continued?

Mr. Martin Varley: Much work must be done on that, which is all quite feasible. The association and its private practice consultant members are willing and able to engage. As was said earlier, we need a tripartite approach to this, in all likelihood, to ensure it is effective.

Chairman: There are witnesses in the committee room if the Deputy wishes to direct any of his questions to them.

Deputy Marc Ó Cathasaigh: I will ask the questions generally and whoever is best placed might provide the answers.

Chairman: If any of the representatives in the committee wish to contribute, they may raise their hand.

Ms Susan Clyne: I will speak to the cancer screening services. The IMO is currently in discussion with the HSE about how screening will come back into place, particularly cervical screening through general practice, as well as other screening services. The screening services were not cancelled on the basis of any agreement with the Government. It is important to remember all non-urgent care, as well as private care, was cancelled across the system. This was right across the system and it did not just affect appointments for private patients.

Deputy Marc Ó Cathasaigh: I thank Ms Clyne. I have a quick final question. Since services began to resume on 5 May, is there a number for the private consultants treating public patients in that timeframe?

Mr. Martin Varley: The numbers of public patients being treated by consultants in private

hospitals is possibly part of a submission on which I have seen reports from the health service management, representatives of which are joining the committee in the afternoon. I have not had the opportunity to look at those figures aside from a fleeting look this morning so perhaps they would be in a better position to provide the data to the committee.

Deputy Duncan Smith: My first couple of questions are for Mr. Varley. Dr. O'Connor spoke to the backlogs of up to six months for public patients. What are the views of the IHCA on the reconfiguration of any new deal with a specific focus on clearing the backlog of public patients? Has Mr. Varley formed a view on that? How can he help, and how would that influence any new deal?

Second, Mr. Varley mentioned in his opening statement that the original rationale for the hospital deal no longer pertains. None of us are prognosticators in terms of what will happen in the future but given what has happened in the past and the data we have on the winter flu, we all agree that the winter flu and any re-emergence of Covid-19 will not be able to exist side by side in our health service. Does Mr. Varley believe that whatever deal comes next will have to take cognisance of the fact that capacity will be needed this winter across both spheres?

Mr. Martin Varley: Dealing with the latter part of the Deputy's question, which I think is the proper place to start, the big question is how we can now configure in our hospital structure, both public and private, the optimum use of capacity. We have possibly lost sight of an element of that in the context of the expansion of bed capacity provided for in the capacity review and in the national development plan, but I am aware also from discussions with the HSE that there are fairly advanced plans to put in place substantial intermediary step-down care beds - something of the order of 1,600 across the country - which are hugely important. In addition, beds had been opened on a temporary basis during the crisis that need to be opened on a sustained basis. That is vitally important in terms of ensuring we have a capacity footprint that is greater than the one we started out with. In particular, opening the approximately 1,600 integrated beds is vitally important to allow us to decant patients from hospitals once their clinical treatment is completed and they need to go on to further care before returning home. There are difficulties there to my knowledge but there are substantial bed numbers in that regard.

The same applies to ICU bed capacity in our public hospitals. Trojan work has been done by everybody to ramp up our public hospital ICU capacity. A lot of extremely good work has been done by consultants on the front line. We need now to put that on a sustainable basis. Let us not forget that about a decade ago the then Government commissioned a report that recommended we should double the number of ICU beds by 2020. We are probably there but only there on an improvised basis. The concerns I am hearing from our public hospital doctors in ICU in particular is that we could lose sight of that. That was the critical exposure we had in terms of dealing with a pandemic and a crisis. We always knew it was a problem in terms of trying to deliver scheduled care and unscheduled care together in a stretched environment. We would like to see us going back to our tripartite discussions. We need to engage with the other parties: health service management, private hospitals, private practice and other consultants.

Deputy Duncan Smith: I have a question for Ms Clyne. She mentioned that an urgent assessment is needed of current capacity and how that capacity will be affected as we deliver care under new social distancing arrangements. Has the IMO formed a view on the two metre versus one metre debate and how that would impact us in being able to meet the capacity and address the backlogs in outpatient departments and every other element of our health service?

Ms Susan Clyne: The IMO would fully support NPHET and its recommendations. If two

metres is recommended by NPHET, we want to operate our health services in the safest way possible. It is not a place to take additional risks to sort out the infection in our health services. The two metre rule is in place at the moment and we would fully support that.

It is not a question of two metres or one metres in the health services because given the lack of capacity and the growing waiting lists, we need much more fundamental investment in temporary builds, staff coming on board and staff getting engaged with management and plans. Consultants, nurses and management in every hospital are looking at this and they are all very worried about how we continue to provide essential services to patients with so little capacity.

Chairman: Dr. Sadlier, did you have your hand up to answer a question? No.

Professor Alan Irvine: I appreciate this is to do with the review of the private hospital deal. There are certainly many learnings we can take from this but we should not be focused entirely on what we will do with the next private hospital deal. We have massive restrictions in capacity. We need to be bold, imaginative and local. We need to look at where good local solutions have worked and how we can get extra capacity for outpatient and inpatient procedures in the public sector also. That has to be an absolute priority rather than seeing how we can do things better in a narrow way with the independent sector. That might be important in the short term, but let us also be bold and imaginative. We are in a special place-----

Chairman: Does Professor Irvine have any concrete, bold or imaginative proposal?

Professor Alan Irvine: Yes, there are imaginative solutions - for example, what Citywest is doing-----

Chairman: I will give some of my own time at the end rather than take somebody else's. I look forward to your contribution. I am sorry to cut across you, but we do not have time.

Deputy Shortall has five minutes.

Deputy Róisín Shortall: I want to thank both groups for their presentations .

Does Mr. Varley accept, in the context of the Covid-19 crisis and the general atmosphere of everybody needing to put their shoulder to the wheel, it was regrettable that more private patients did not sign up to the local contract?

Mr. Martin Varley: Is that in the context of private practice consultants?

Deputy Róisín Shortall: Yes.

Mr. Martin Varley: We have to see this through the prism of the situation the private practice consultants found themselves in. As I said earlier, they had a Hobson's choice. Would one sign a contract that constrained or prohibited one from providing continuity of care in one's outpatient clinics? I have spoken to many consultants in those circumstances. I should add that private practice consultants in different specialties found themselves in different situations. If one was an anaesthetist the same circumstances did not apply as would to a cardiologist, medical oncologist and others. This explains why some were in a position to sign up and others were not. I have seen some of the room costs of medical and respiratory consultants in private practice. The lowest is €6,000 per month increasing to €10,000, €15,000 and €20,000. In my view the failure was not, in fact, that private practice consultants were not engaging. I estimate I have spent 80 to 100 hours a week on issues trying to unblock the obstacles, together with our private practice consultants, so they could sign up.

Deputy Róisín Shortall: Nevertheless, there was a massive national effort under way and in that context it might have been better if more people had signed up.

Mr. Martin Varley: Could I finish on one point? The vast majority who could not sign up offered *pro bono* services in their hospitals to treat public patients. We should not lose sight of that.

Deputy Róisín Shortall: I wish to raise some questions with Ms Clyne and the IMO. I note the comments Ms Clyne made with regard to the NTPF diverting important funding away from the public health service. I very much agree with those points, and that should be taken on board by people involved in negotiations at the moment.

It is regrettable the decision was taken by Government to end the arrangement at the end of June, because there was huge potential. In the context of no distinction being made between public and private patients in the treatment of Covid-19 patients, it would be great to see that same kind of effort made on non-Covid care, with single lists being operated and all of the capacity within the public and private hospital systems being used at least until the end of the year. If we avoided a second surge or wave, real progress could have been made through the waiting lists for all patients. It is regrettable that did not happen. There is a strong argument for the State to retain the use of at least a few private hospitals in order to operate them as elective-only hospitals. There is commitment to developing elective-only hospitals at some point. Would Ms Clyne accept there is a strong case for retaining some private hospitals for use as elective-only hospitals, as happened in Scotland where a private hospital was bought for that purpose?

Ms Susan Clyne: Yes, we would like to see some elective-only hospitals in place. I do not think we spent long enough on the arrangement with the private hospitals in terms of deciding what everyone wanted from the system. The Government is going to end the agreement. We do not know what the new agreement will be. The HSE, I suspect, had a vision or a plan to use these hospitals for elective work. We must do something rapidly about our waiting lists. However, even with the private hospitals, it is not a long-term or even a medium-term solution. There is still not enough capacity or consultants in the country when one adds the capacity in the public hospitals together with the private hospitals. We really have to invest in acute hospitals, in beds, and in consultants to deliver care to patients.

Chairman: I thank Ms Clyne. I am going to have to reduce each slot to four minutes from now on to get everybody in.

Deputy Paul Murphy has four minutes.

Deputy Paul Murphy: I suggest in future that we should do that throughout, rather than those who are at the end getting cut off.

Chairman: I appreciate that. I am sorry. There was much procedural discussion at the start.

Deputy Paul Murphy: As general comment first of all, it is unfortunate the discussion happens in the context of the horse having bolted, with the Minister and the Government having taken the decision to effectively return to what looks like a two-tier health service, combined with a supercharged NTPF. That looks like where they are going. It seems to suggest that it is not okay to treat people according to wealth when they have the coronavirus, but it is okay to do so when they have cancer, heart disease, or depression. Instead of going backwards, we should be going forwards to a national one-tier public health service.

I refer to the details of the deal with the private hospitals. I was a critic of it, and I thought it appeared extremely expensive. I agree when Mr. Varley says that it represents very poor value for money. His basis for that is primarily based on usage, that is, there is a huge amount of excess capacity and we are only using a certain number of beds, therefore it is very expensive per bed used. However, according to the figures published in Britain on the deal between the NHS and private hospitals, even on a per-bed basis, regardless of usage, the deal looks very expensive. In Britain, the average cost per bed is about €10,000 per month, whereas in Ireland it is about €44,000 per month. Has Mr. Varley any insight into why the deal appears, on a per-bed basis, to be so expensive?

Mr. Martin Varley: I do not have full detail on that, but I recall commentary on it at the time, in the early stages. My understanding, and this is subject to verification, is that the agreement entered into with the private hospitals in the UK effectively allowed more flexibility in terms of what was being purchased and taken over, so to speak. As such the private hospital deal in the UK allowed the possibility for capacity that was not required to be used to treat the patients in those hospitals that would otherwise require urgent care. That in some respects would account for the fact that in the UK, they were probably - I stress probably because I do not have all the detail - paying for the capacity they sought, but it not being all the capacity in the hospital, or else the capacity being used. In the private hospital agreement here, however, I think it was covering all the capacity. That is the sort of detail that becomes problematic in trying to optimise capacity and getting good use of it.

Deputy Paul Murphy: To follow up on that, I have been trying to get access to both the April cost provided by the private hospitals, and a full breakdown of the costs from the Government. They are refusing to give me any of the figures, which makes it very difficult for us, as public representatives, and the public in general to make a decision on whether or not it is good value for money because we do not have any figures to go on. Would Mr. Varley agree we need to have more transparency in terms of the costs, the deal, etc., so that people can make an informed decision about it?

Mr. Martin Varley: In particular in circumstances like this, transparency is hugely important, so I can only agree with the Deputy's suggestion.

Deputy Paul Murphy: I thank Mr. Varley. Does the IMO have any comments to make on that? In particular, I note its comments about the NTPF. It seems that is what the Government is gearing up for, a more extreme NTPF with all the inequalities, and so on, which go from that.

Dr. Anthony O'Connor: Our position would have been that it was premature to abandon this deal before there was a proper roadmap for reopening the service for public patients as well, because their lives matter too. People talk about a second surge and what might happen. They say we could have hundreds of people lying on trolleys, overburdened intensive care unit capacity and operating theatres closed for a month. That is January every year in the Irish health service. What could be coming if we do not address it could be apocalyptic. We need to find a solution. If we say the NTPF might be the solution, then we will have to use it in a way that we have never used it before, and we had better get started with it.

Deputy Shortall made the suggestion about putting some of this on a more permanent footing. That is another option but whatever we do we need to set about it fairly quickly.

Chairman: I thank Dr. O'Connor and Deputy Murphy. I call Deputy Shanahan for the Regional Group. He has four minutes. I am sorry but we are reducing slots to get everybody in.

Deputy Matt Shanahan: On the deal done in early March, how soon does Mr. Varley think the alarm bells started to ring for his organisation that the capacity there was not going to be utilised? When did the IHCA bring that to the Department's attention forcefully?

Mr. Martin Varley: We brought it to the Department's attention quite early on in our discussions with officials. We did that for the simple reason that we were very concerned about continuity of care for patients of private practice consultants. We could see that the contract being offered to our members was cutting across that and our members were concerned about events happening for cardiac patients, oncology patients and others that would be detrimental to their health. We flagged it quite early on and because we were making so little progress we wrote to the Minister on 30 April outlining that this arrangement was going to prove extremely poor value for money, poor value for patients and there was a very high risk we would not be able to utilise the capacity to the extent that we should.

Deputy Matt Shanahan: Given that there was a lack of activity in the public and private hospitals and understanding the efficiencies that were available in the private sector, does Mr. Varley think there was an ideological component to the Department's arrangements *vis-à-vis* the full-time private consultants?

Mr. Martin Varley: I struggled to understand the reasoning behind many of the exchanges I have had with the officials. I recall at one point saying to an official that we had 600 consulting rooms that provide very valuable outpatient clinic care to patients. I said it was like cutting off one's nose to spite one's face to ignore this vital capacity that we need more than ever during a crisis. I was pleading with the officials to understand that what we were doing was not going to be optimum.

Deputy Matt Shanahan: With respect to where we go from here, we have heard the doctors and the IMO speak about the dangers of a surge later in the year. I do not agree with my colleague, Deputy Murphy, about the NTPF. What we know about the present model, whatever the future model might be, is that if one incentivises activity, one gets increases. At the moment, the only way to do that is within the private hospital sector. Where does Mr. Varley think we are going in terms of the NTPF? Can we streamline patients through the NTPF to get more elective procedures done?

Some of the private hospitals have already invested in polymerase chain reaction, PCR, testing, which gives results within 20 minutes. This should allow a far safer movement of patients, and potentially care staff, through the hospital. Is this something the IHCA would try to progress as quickly as possible? That seems to be a way to speed up efficiency and to counter some of our capacity issues.

Mr. Martin Varley: As mentioned by Professor Alan Irvine earlier, we have to optimise the use of our capacities across all aspects of our healthcare delivery. We are in a very challenging environment and we should do so.

It is very important that we advance the 1,600 or so intermediary care beds so that we can streamline the stepdown care for patients coming from public hospitals. Otherwise, many beds in public hospitals will not be available to provide scheduled and unscheduled care to patients. There are 12,000 to 13,000 beds in our public hospitals and 2,000 beds in our private hospitals. The bigger opportunity is in our public hospitals and in putting in place additional capacity for public care. Our members on the ground, in public and private hospitals, have demonstrated much agility and innovation during this crisis. They brought things in very quickly. They are

more than happy to engage, as we go into the winter, to avoid problems that would otherwise arise.

Chairman: I now call Deputy Michael Collins. He has four minutes. I apologise but we have had to reduce time.

Deputy Michael Collins: I welcome the witnesses. Do they think the takeover of private hospitals was done in a hasty and poorly thought-out manner?

Mr. Martin Varley: Everyone can understand the circumstances that we were in in March. Everyone was fearful as to what was coming our way. The agreement was entered into in those circumstances with the best possible intentions to protect the population and to protect our front-line workers. The agreement was hasty, but probably necessarily so. Where it probably fell down is that there was not enough engagement with the hospital consultants who would be critical in delivering the care in those private hospitals. The analogy has been drawn that the agreement effectively rented the aircrafts but did not enter into appropriate consultation with the pilots who were necessary to deliver the service. That is probably the main failure and the main lesson that we must learn as we go forward. Engagement across all spectrums with all the stakeholder groups is hugely important.

Deputy Michael Collins: Was the decision seriously damaging to public health?

Mr. Martin Varley: We are in an environment where the health service and health services generally had been hugely challenged because of the crisis. Yes, some damage has been done because we have not optimised what could have been done in private hospitals. Care to urgent non-Covid patients has been prohibited and frustrated and care for non-Covid urgent patients in public hospitals has also been delayed. This is anything but an ideal environment. We could have done better, as we have alluded to, by putting more practical arrangements in place to allow private practice consultants to operate their suites and outpatient clinics to give timely care to their patients. They were more than happy to do that, together with providing care in the private hospitals, as had been requested. That was not facilitated and that was the huge problem we had.

Deputy Michael Collins: Was the decision correct to deny 2.2 million people their legal rights to gain access to what they paid for?

Mr. Martin Varley: There is another broader discussion there. As I outlined in my opening statement, 46% of the population had maintained their health insurance. They rely on the private hospitals to a large degree and the private practice consultants provide that care. That is good for public hospitals because we do not have sufficient public hospital capacity. As I said, there are 12,000 beds in the public and 2,000 in the private; we must use them to the optimum degree. I am sure those who had health insurance will look forward to a situation where, if they have a requirement for urgent care, they can access it with their consultants and that will give continuity.

Deputy Michael Collins: Was there much inaccuracy in statements issued by the HSE on this issue?

Mr. Martin Varley: We would have seen that and been concerned about that. Much of our engagement has been absolutely collaborative. I have all my communications with me. They have also been constructive. That has been our approach as an association and has been the approach of our members. However, it has not been reciprocated in a similar manner which I

regret hugely, especially during a crisis. We have operated with absolute integrity in these matters. On occasions, it has been portrayed otherwise, which I find extremely regrettable.

Chairman: I am conscious that Dr. Sadlier in committee room 1 wishes to contribute.

Dr. Matthew Sadlier: The answer to the Deputy's question is that we must ask ourselves why we needed to do this. Why, in a public hospital system, did we need to look for extra capacity in the private system? It is because we have had so many years of under investment into the public hospital system. We talk about beds in the public hospital system but there are other things we could have done that would have helped and facilitated the move to the private hospitals. We cannot let today's meeting finish without making sure that three things are clearly stated. First, is the investment that we urgently require in the IT systems within the hospitals. Within mental health, where I work, we have been asked to move to telemedicine, but that is not possible unless one has computers with cameras and microphones, which almost none of the primary care centres and mental health teams is facilitated with.

Second, the private hospital spread around the country does not reflect the geographical spread of the population. There was, and still is, a possibility with some of the money that was being spent on this deal to introduce generational changes, whether it is through modular builds or temporary builds to expand bed capacity in areas of the country where due to population spread there is no private hospital alternative.

Third, we cannot under any circumstances leave today without emphasising the damage that the 30% cut to consultants' salaries in 2012 has done to the recruitment and retention of specialist staff within the public healthcare service. We can talk about capacity in terms of beds and buildings as much as we like, but if we do not have the specialists within those buildings to provide the care for the patients the buildings are fundamentally useless. Ultimately, what is going to happen in the coming months is that there will be an unprecedented demand for medical expertise across the world. Within the English-speaking medical world we have always been the country that has paid the least and has been the least competitive in terms of being able to recruit specialist staff. If we do not address the 30% cut urgently, we could be in a far worse place when the autumn and winter come. As my colleague Dr. O'Connor said, we will have an apocalyptic situation if we get hit with flu and Covid at the same time.

Chairman: I thank Dr. Sadlier very much. The next Sinn Féin speaker has seven minutes and there are also two four-minute slots. Deputy O'Reilly went over. I am just doing the best I can to be fair to everybody.

Deputy Matt Carthy: We will talk about that another time, a Chathaoirligh. I thank the witnesses for their contributions today and for their frank responses so far.

Could any of the witnesses give an indication as to how many Covid-19 cases have been treated in private hospitals since the deal was negotiated and agreed?

Mr. Martin Varley: I do not have those figures. I suspect the number of Covid-19 patients in private hospitals is relatively low. I think some cases presented in the early days in one of the private hospitals in Cork and I am sure there were occasions elsewhere where similar presentations would have occurred but, in the main, the intention was that the Covid-19 patients would be treated in the public hospitals.

Deputy Matt Carthy: Is that view shared by the IMO or does anyone in the committee room have additional information?

Ms Susan Clyne: We do not have those numbers but I think it is true to say that the public hospitals, in the main, have dealt with the Covid issue.

Deputy Matt Carthy: We have been paying €115 million per month for the use of private hospitals during this period. The corresponding figure we were given for the deal that was done with private hospitals by the NHS in Britain is €82.5 million. I accept there will always be distinctions between different healthcare systems but according to the figures I have – I am open to contradiction – it works out roughly that our deal equated to €44,000 per bed per month while the equivalent deal in Britain was closer to €10,000 per bed per month. Dealing with the issue from a staffing point of view, our deal worked out at €14,000 per staff, per month compared to the British figure of about €4,000 per staff, per month. Could any of the witnesses shed light on why there would be such divergence in those figures?

Mr. Martin Varley: Unfortunately, I do not have visibility of the detail and I have not had an opportunity to examine it.

Deputy Matt Carthy: Does Mr. Varley see any reason we would be paying over three times the amount?

Mr. Martin Varley: As I alluded to earlier, I do not have all the facts, but it is quite possible that the agreements differ in terms of the basics of the agreements. The agreement here was to acquire access to all the capacity and pay for it, as such, whereas I think - subject to verifying this - the UK agreement may be around payment for capacity used or sought but not all of it. Therefore, it allowed the private hospitals in the UK to also continue to provide care to private patients in terms of continuity of care as well.

The agreement was entered into in a very extremely difficult and challenging circumstance whereby most of us were of the view we were going to be overwhelmed with patients infected with the Covid virus and everybody approached that with the best possible intentions. Where we have slightly gone wrong is that there has not been flexibility in terms of how the agreement works in practice.

Chairman: Mr. Irvine is in the committee room and would like to comment.

Deputy Matt Carthy: Mr. Irvine is welcome.

Professor Alan Irvine: To give a brief description, the deal we did here was to take over the complete command and control of all of the running costs of the Private Hospitals Association, PHA, hospitals, whereas the British deal was more titrated towards activity delivered and it did not take over the entire operation of the hospitals. That is going to account for quite a big discrepancy in the per-bed costs when one reduces it down to that. Obviously if one buys and pays for 100% capacity but uses 20%, 30% or 50% then that will skew the costs per unit item.

Deputy Matt Carthy: Two questions flow from that. Clearly, the understanding we have from media reports of the Government's intentions is that it is moving towards that model. Is there any particular advice that we need to give? Either set of speakers are welcome to answer my question. Was the Government in a poor negotiating position for the original deal considering it had essentially announced the deal before negotiations had started? Therefore, it needed to bring the deal over the line because of the additional pressures that were placed on it. In other words, did the private hospitals manage to get an incredibly good deal in return for what was actually delivered over the past number of months?

Ms Susan Clyne: The reason this or any Government would be in a poor negotiating position is because the public health system has been so underfunded, has too few beds, too few doctors and increasing demand.

On the detail of the negotiations or the deal with the private hospitals, we were not involved in any of those negotiations. We really do not want the committee to lose sight of the following fact. Whatever arrangement the Government now enters into with the public hospitals - and it will need to enter into some kind of an arrangement with them - needs to be based on prioritising clinical need while at the same time investing in public services. This cannot be another excuse to say, "we are doing this, we have this capacity so we don't need to do anything in the public service". The public service is crying out for beds and manpower, and we need to do that now.

Deputy Matt Carthy: I agree with all of that. Issues were raised at the end of the last round of questions. What level of investment is required for IT systems? Are there particular areas of practice where the IT systems are frustrating the provision of a healthcare system within the public system?

I noted the comments and very strong focus that was put on the salaries for consultants. Does the IMO have an equal position on salaries for other front-line workers, particularly nurses, doctors, primary healthcare providers and others?

Ms Susan Clyne: I will deal with the salaries for consultant posts and then my colleague, Dr. Sadlier, will deal with the IT staff. All healthcare workers should be rewarded appropriately for their post. The issue of the salary for consultants is regarding a specific and unique cut that was imposed in 2012 on consultants only that was on top of all of the other financial emergency measures in the public interest, FEMPI, cuts that all healthcare workers suffered. It is an extra 30% cut that was targeted - and politically targeted - at consultants. It saved the State hardly any amount of money but destroyed the health service and destroyed the recruitment of consultants into the public system and we are still suffering from that cut now.

Chairman: I thank Ms Clyne. Does Dr. Sadlier wish to say something?

Dr. Matthew Sadlier: To answer Deputy Carthy's questions on information technology, the IT systems in Irish healthcare are abysmal. That is the only word one can use. Anyone walking in to most Irish hospitals will see we are using the same methods - paper and pen and cardboard charts that get filed - as were used in 1890. When patients come in to the emergency department, the only records we have of them are in a cardboard file that has to be dragged up from a basement. In the era of information technology, we could use collaborative working platforms. When we try to attend remote team meetings, as we all had to do overnight, we are not able to do so. There are information systems available that work very well.

Deputy Matt Carthy: Could we ask the IMO to prepare us a paper on that? That would be very useful.

Chairman: I thank Deputy Carthy for that constructive suggestion. Would Dr. Sadlier be happy to provide a written reply?

Dr. Matthew Sadlier: Yes, we can do so.

Chairman: I thank Dr. Sadlier for his understanding.

Deputy Colm Burke: I thank both the IMO and the Irish Hospital Consultants Association for their presentations. On the agreement between the Department and the private hospitals, I note Mr. Varley makes no reference in his presentation to any contact between the IHCA and the private hospitals. In view of the fact that the private hospitals were the places where the IHCA's members worked, was there at any stage over the past two months ongoing consultation with the private hospitals?

The agreement will not be renewed after 30 June, although there will be a new agreement. Has the IHCA set out its stall with the private hospitals as regards how an agreement can be reached between all parties as opposed to having the Department and HSE reach an agreement with the private hospitals and leaving the consultants out? I am wondering about the communication the IHCA had. The same question applies to the IMO as regards the consultation it had with the private hospitals.

Mr. Martin Varley: We had discussions with the private hospital associations, in terms of their executive and CEOs, at an early stage when we became aware of what was being proposed. We outlined all of our concerns *vis-à-vis* the need for a contract that would be practical and workable from a consultant point of view. That was during the latter half of March. If we cast our minds back to that time, the overwhelming view I got from those discussions was that there was a shortage of time and a lot of pressure, and people were trying to get an agreement. Members will have seen that in the media. We highlighted and flagged the problems, which become more apparent as the agreement went on. In particular, we stressed the need to deal with those problems.

In relation to the type of contract, it seems that health service management presented only one option and was absolutely inflexible therein. There was no room for us as an association to get a hearing on what were reasonable points. Even though we engaged with health service management from mid-March onwards, a significant hiatus arose between those discussions and follow-on discussions whereby there was not enough feedback and engagement from the officials until after the agreement was signed with the private hospitals. Unfortunately, an opportunity was lost in that period.

Deputy Colm Burke: Mr. Varley's main criticism seems to be with the Department and the HSE. Does he not accept that there should also be criticism of the private hospitals given that the IHCA was excluded and the private hospitals did not seem to respond to its concerns?

Mr. Martin Varley: The Deputy has summed it up well. The main criticism was with the officials who have a responsibility to engage and to ensure whatever arrangements the Government puts in place work well. As I said in our earlier discussions, on matters such as this, we need tripartite discussions between health service management, representatives of private hospital and representatives of private practice consultants. When one of these is neglected, one ends up with a situation such as was described earlier in which it is as if one pays a lot of money to hire aircraft without engaging with the pilots. That is extremely regrettable. Our members wanted to commit to this huge national challenge and did so despite a suitable contract not being available. As a result, not all of them could sign the contract. We need to make sure any future engagement is carried out on the basis of the necessary considerations being taken into account in shaping any future arrangements.

Deputy Colm Burke: The IMO may want to come in on my next point. With regard to future arrangements, if there were to be 80% or 90% occupancy in a private hospital and the Department suddenly concluded that a surge was on the way, how many days would it take to

make beds available?

Ms Susan Clyne: I am afraid we do not know the answer to that. If hospitals are operating at 80% or 90% capacity while we are waiting for a surge, we will be in real trouble.

Senator Colm Burke: If one was to take the average stay of a private patient in a private hospital into account, surely one could estimate how long it would take. Should we now estimate the capacity above which private hospitals should not operate?

Ms Susan Clyne: We make the point that the public services and the private services should open in tandem, based on patient clinical need, so that we will know where we are across the system at any one time. In designing the new agreement, we will have to consider what exactly we now want from the private hospitals. Is it to be like the UK model, in which some targeted purchasing is negotiated? We hope it will not be based on the National Treatment Purchase Fund system but are greatly concerned that it will be.

Dr. Matthew Sadlier: Ultimately, one of the main arguments raised here is a little false. In normal times, the public hospital system operates at near 100% of capacity, as does the private hospital system. While in an emergency period of a number of months the capacity for elective care in one or both of those systems can be reduced, the demand ultimately builds up and will come into the system. The overall system ultimately needs more capacity. We need more beds than the public and private systems combined can provide. That is the ultimate problem. If we were to go back to using the private system for public patients or for surge capacity, all we would be doing is causing a build-up of patients which will leak into either the public system or the private system. Ultimately, we need more capacity in the country, regardless of the system it is in.

Senator Colm Burke: To return to the issue of capacity, do the witnesses have experience of modular hospitals? Have they been successful?

Dr. Anthony O'Connor: We had modular builds in Tallaght University Hospital for quite some time. They helped us with our capacity. It is now on a more permanent footing. It was also tried to good effect in South Tipperary General Hospital. We know it can be done; we have seen it happen all over the world in the past three months.

Senator Colm Burke: How long do such buildings take to construct from start to finish?

Dr. Anthony O'Connor: When the urgency is there, things can happen very quickly. That is an important thing we have learned in recent months. I cannot stress enough that what we consider a surge is the norm in our hospitals every winter, so we need to get ready now. There is plenty of time before winter for us to get modular capacity if that is what is needed. There is loads of time right now.

Senator Colm Burke: With regard to the IT system, I understand that maternity services have been computerised and that this is progressing section by section within the health system. What progress has been made over the past two years?

Dr. Matthew Sadlier: It depends on the section. I could provide a very long answer to this question but I will be very quick. Ultimately, we need a single integrated system across all hospital sites. Individual hospitals with individual systems that do not integrate do not provide value for the overall system. By the nature of our health system, most patients go to more than one institution for their healthcare, depending on the specialty they require or the problem they

have. The maternity hospitals are a great example, particularly in Dublin which has stand-alone maternity hospitals. There is a very good point to those maternity hospitals having a system for themselves, but when those patients have another health problem that is not related to their pregnancy or childbirth and they go to one of the public hospitals, if the information digitally recorded in the maternity hospital cannot follow the patient to the other hospital, it is underutilisation of a system.

Deputy Colm Burke: I understand that over the past three years, this system of computerisation of patient records has been developed across all the maternity hospitals.

Dr. Matthew Sadlier: It needs to integrate into the other general hospitals. Patients may have other health problems that are potentially not related to their pregnancy or childbirth and they may attend a general hospital where information from the maternity system is not feeding back into the general hospital. The computerised system is good for one health journey the patient has had, but a life is full of multiple health journeys. The information technology system should follow us through that.

Professor Alan Irvine: The individual health identifier has been on the statutes in various committees for 16 or 18 years. It would make a huge difference. It rests here in the Legislature, not on the operations side.

Deputy Stephen Donnelly: I thank all of the witnesses for coming to the committee. I thank their respective members for the Trojan work they have done over the past months. It has been quite extraordinary to see the level of skill and dedication as an entire clinical system geared up for a disease we had no idea how to treat when we did not know what it would do to our population. It has been an incredible show of skill, professionalism and dedication across the clinical community. I thank all of the witnesses' association members for everything they have done and continue to do.

I believe that taking over the private hospitals was absolutely the right thing to do. It was a bold, brave decision to deal with the surge. Once the surge did not happen, however, they should have been given back pretty much straight away. It is my sense that the new rationale for holding on to them to use as additional capacity has been an implementation disaster. It was always going to be very difficult. For June, I do not understand why the contract was not ended last week. I cannot find anybody who believes that the contract makes any sense now for patients, be they public or private or anyone else. In his opening statement, Mr. Varley stated that some 250,000 operations under general anaesthetic are done per year in the private system. That is approximately 21,000 per month, which is a lot. It is two in every five surgeries performed under general anaesthetic in the State in any given month. Given that this deal means we are getting about half of what we should be getting from the private system, does Mr. Varley believe it reasonable to say that continuing this contract for June means that approximately 10,000 patients - which is a ballpark figure - who need surgery under general anaesthetic will now not get that surgery?

Mr. Martin Varley: The Deputy's broad analysis is correct. If we are operating at 30% of 40% capacity in bed utilisation, and if we allow that some of the patients who had been transferred to private hospitals are at the end of their clinical care, then perhaps the real impact is somewhat lower. At 30% or 40%, and even allowing for Covid-19 restrictions, it is quite possible we could have used our private hospitals to the extent of 60% or 80%, depending on circumstances. We are aware from our private practice consultants that care has been delayed at outpatients clinics and for follow-on care that may be required in hospitals.

Deputy Stephen Donnelly: Is it Mr. Varley's understanding, and I put this question also to the clinicians here today, that some of this delayed care as a result of lower capacity is cancer patients and urgent care including diagnostics, outpatient clinics or surgery?

Mr. Martin Varley: Yes, unfortunately. I have spoken to many consultants, medical oncologists, urologists and other specialists who treat cancer patients. They have been extremely frustrated. They cannot get the contract to work to provide the timely care they want to provide for their patients.

Deputy Stephen Donnelly: I thank Mr. Varley. Do any of the representatives from the Irish Medical Organisation, IMO, want to respond on the care that is being missed at the moment?

Dr. Anthony O'Connor: It is a huge concern. If we cancel the contract immediately, it would mean that those 10,000 operations can happen but it bears no relation to need or urgency. One could have a situation where the private sector is allowed to operate as it normally does but the public patients are still completely locked out of all elective care and all cancer care. That is why this organisation was calling for both arms of the service to be opened up in tandem according to clinical need, with urgent time-sensitive stuff first, maybe something like chronic non-malignant disease after that and then opening up more gradually while seeing if there is any more benefit we can wring out of this deal for however long is left, be it a month or whatever.

Deputy Stephen Donnelly: I will come to that and I agree. When I advocate for the ending of this contract, it is not to go back to the *status quo* where public patients cannot access it. I am just trying to get a sense for the total quantum of care that we can now deliver to people in this country. I do not really care if they are public or private; they are people who need care. If there are 10,000 fewer of them having surgery this month because of what I think everyone knows is a bad deal, that is worth putting on the record. I have a quick question and would like a general response. In terms of value for money, am I right in thinking that under this contract, for the last few months and for this month, public money will be used to have private patients as well as some public patients treated in private hospitals by private doctors? Essentially, operations and procedures that would normally be paid for by the insurance companies are being paid for out of the public purse.

Mr. Martin Varley: That is the situation. On the basis of the contract that was drawn up, the normal billing that could have arisen for privately insured patients was not provided for. Therefore, the State is paying for the use of that capacity whereas the private health insurers could have funded it and would have been happy to do so.

Ms Susan Clyne: Under the legislation, all private patients became public patients.

Deputy Stephen Donnelly: We understand but essentially they were private patients. Their insurance companies were going to pay for their care and treatment and we stepped in and said we would pay for it instead, if they can get it. My final question is probably more for the IMO but also for the IHCA. It is about solutions. We now have a perfect storm. We have lost 20% of beds in our public hospitals by going from about 100% to 80%. In her opening statement, Ms Clyne referred to a loss in capacity of up to 50%. Be it diagnostics or outpatients, a lot of doctors are saying that is what is going on. We need solutions and we need them for this year. That reduced capacity is going to stay with us. There is a fear that our entire healthcare system is going to be overwhelmed by an increased level of demand at the same time as a massive reduction takes place in capacity and huge additional expenditure needs arise around PPE, testing and tracing. A new care area, namely Covid-19, has also arisen along with a €30 billion deficit

in our finances. We need solutions to increase capacity now. As we know, building hospitals takes a very long time. Have the witnesses solutions for what we can do to increase capacity immediately?

Ms Susan Clyne: Yes, and we have outlined some of them in our submission. We need an assessment of what is available now. For example, Citywest Hotel was set up with a number of beds to be used for Covid. It is now not being used for Covid but we have rented it so we can use it for something. We have to use temporary modular builds. We have to help hospitals located outside of the big regions, like Wexford, and put in extra beds there. We accept that the building of a hospital takes a long time but it will take longer if we do not get it started. Temporary modular builds have to start taking place. We have to be innovative and work with GP colleagues to see how we can streamline services between general practice and the secondary care system. We have to recruit doctors. We have a significant number of non-consultant hospital doctors, NCHDs, in the system who are due to finish their specialist registrar, SpR, training posts in July. They should be offered an acting-up consultant post immediately. It is possible to do that. We also have NCHDs who are due to finish various contracts in July who have not been guaranteed any posts to stay in the Irish system. While we are saying we need all these doctors and more, we are allowing another generation of doctors to leave the country.

Professor Alan Irvine: We need to massively increase the workforce. We talked earlier about correcting the 30% pay cut, which is really important in recruiting the next generation of consultants, a point we cannot emphasise enough. If looking for solutions in a broader system, one will find them mostly grown locally and from listening to local clinicians, nurse leaders and hospital leaders. One will find that if one talks to people working in Wexford, they will know what is best for Wexford and how best to get its capacity. There may be office blocks that can be repurposed as outpatient clinics with social distancing or additional beds that can come in for modular builds. There is a great deal of expertise locally if one really listens to the people who know their business best. It will not work on a central command and control, top-down system. That never works and it is just forced on people. The best and most innovative solutions will be in local communities with local clinicians and nurses.

I recommend fixing the pay cut, getting more people on the ground and listening carefully to local solutions. They should be given money and empowered.

Chairman: I thank Professor Irvine and call Mr. Varley.

Mr. Martin Varley: To respond to Deputy Stephen Donnelly's question, we need to accelerate the opening of beds. A great deal of work has been done on opening and planning for intermediary beds for step-down. It is of the order of 1,600. In addition, we have improvised within the system to bring back into use approximately 1,500 acute hospital beds in public hospitals. They have to be opened and be put on a sustainable footing. To do so, we need to fund them, as has been outlined over many years, and to staff them. The service cannot be run on an overstretched basis. I go back to the fact that between 500 and 600 of our permanent consultant posts are vacant. The Government has taken a decision that we should end the discrimination and bring back those consultants, and that is a high priority if we want sustainable services during a peak.

Our IT facilities for radiologists reporting are far less than is needed. We have had engagement with the HSE on it in recent weeks and we just need to put in place proper IT services to allow people to work effectively and build on what has been a lot of agility and of innovation demonstrated by our consultants and hospital doctors in recent months.

Chairman: I thank Mr. Varley and call Dr. Sadlier.

Dr. Matthew Sadlier: One of the tragedies of the past ten years of the health service, since the 30% consultant pay cut was introduced, was that 52% of interns, on completing their intern year, would emigrate. We now have an historic opportunity, largely due to restrictions on travel and on countries bringing people in, to retain our interns in July of this year and to increase our medical workforce. As Ms Clyne said, this is an historic opportunity where, as people are coming off their training schemes and getting their specialist qualifications, we can hold them in the country. Interns will have to stay in the country. This is an opportunity where we will not only expand the workforce but also have the expertise that will fill that expansion.

Chairman: I will ask a couple of questions in the remaining time. Ms Clyne mentioned screening. What is the medical block to carrying out cancer screening, such as CervicalCheck, mammograms, etc., in Ireland? Will she explain the delay in returning to screening in Ireland, which seems to be greater than in other countries?

Ms Susan Clyne: On CervicalCheck, we hope to be able to return to that screening. The delay is to ensure that all parts of the system are working together. While tests can be carried out safely in general practice, we cannot do a lot of tests and then find there is not the capacity within the hospital to call back women who need to be seen. It is because screening is done at multiple locations, and the more complex the case, the more locations the woman may have to go to.

Chairman: It is a capacity issue rather than it posing a particular risk to front-line staff who are carrying out the tests.

Ms Susan Clyne: It is a complete capacity issue.

Chairman: Dr. O'Connor stated that, coming into this, there was a waiting list of 700,000 people, and he had a fairly dire prediction. What is the waiting list in the public health system likely to be in November?

Dr. Anthony O'Connor: That will be a function of how many appointments are conducted under normal circumstances that have not been conducted. Unless we get the system back up and running for routine care in the public sector, we could be looking at 1 million people by November or December.

Chairman: Could 1 million people be waiting?

Dr. Anthony O'Connor: It would not surprise me.

We have an opportunity. Maybe we can get the public outpatients system up and running a bit more quickly than that and then that would not be the case. It is not inevitable but there is time to act on it.

Chairman: Professor Irvine was going to give an example of innovation and new methods that could be used. Having asked him, he said he had some proposals but I did not give him the opportunity to outline them. Will he briefly outline them now? The committee would appreciate any additional ones in writing.

Professor Alan Irvine: One needs to ask locally each organisation what will work best for them to fix their particular problems. To get systemwide solutions, one can look at core matters like IT and health identifiers. These should really be implemented for efficient running across

the public system and better identification of patients and their needs.

To get innovative solutions, Ms Susan Clyne already mentioned looking at CityWest. There is much capacity and many spare office buildings around which can be used for low-level outpatients which we really should embrace to expand public capacity and its footprint.

Chairman: On capacity, we have set up hospital clusters. There are acute hospitals with tier 2 hospitals around them typically right across the country. Does Professor Irvine think additional non-Covid capacity would be better developed in the acute hospital or is there a role for the tier 2 hospitals with greater care being provided in those?

Professor Alan Irvine: Tier 2 hospitals are hugely important. They get through much less complex work and give people the best care closest to home when they can. They need to be supported too. However, as has been frequently referenced, we run the public system at a 90% plus capacity. Now with social distancing that will come down. The HSE has stated it wants it to be 80% maximum. Our throughputs are going to be shredded as a result. The IMO submission stated 50% which is probably about right. It is probably at the higher end if we are trying to go from 40-patient clinics to 15-patient or 20-patient clinics. We are going to need much capacity, footprint and flow, much more than what we already have.

The level 2 hospitals are also cramped and overcrowded. They need capacity and modular build, just as much as the level 3 and level 4 hospitals.

Chairman: We are repeatedly told that there is a difficulty in getting consultants to go out to tier 2 hospitals to carry out procedures. Will the Irish Hospital Consultants Association comment on that?

Mr. Martin Varley: I have seen some commentary to that effect. When I have checked it, however, it has not always turned out to be correct in terms of the reflection. I am aware that in the midwest, the Chairman's own region, there were commentaries to the effect that consultants were not going out. When I checked it, however, there was a long list of consultants who go out to practise.

The bigger issue is that there are restrictions on the type of procedures they can do in model 2 and model 3 hospitals. It also depends on the support facilities available. There is a range of procedures one can carry out but some of the rest have to be done in the centres with high levels of support.

Chairman: Did the Irish Hospital Consultants Association become aware that it was a type A only contract in advance? Was there any consultation in advance? Was the organisation consulted in advance when clinical indemnity was removed from consultants for testing of their existing private patients?

Mr. Martin Varley: I first heard of the type A contract through the media. Thereafter, I had engagements so it was an iterative process. We outlined our concerns and the contract was signed without those being taken on board. Could the Chairman repeat his second question please?

Chairman: I asked about when the indemnity was being removed - because of the threat, well it was not a threat - for testing.

Mr. Martin Varley: Indemnity was removed in two respects. First, in terms of *pro bono*,

I found out at 6 o'clock on a Friday evening on a bank holiday weekend. I had to inform my members at 9 o'clock or 10 o'clock by the time I got my communication out. This created huge problems.

Likewise for specimen reporting, I became aware of it after the event.

Chairman: I apologise for cutting across everybody's answers but we are over time. I thank the witnesses for attending the committee today and for their answers.

The sitting will resume at 2 p.m. with Deputy Carroll MacNeill in the Chair.

Sitting suspended at 1.10 p.m. and resumed at 2 p.m.

Deputy Jennifer Carroll MacNeill took the Chair.

Use of Private Hospitals (Resumed)

Acting Chairman (Deputy Jennifer Carroll MacNeill): This is session 2 on the use of private hospitals. From the Department of Health, I welcome Mr. Jim Breslin, Secretary General, and Mr. Greg Dempsey, deputy secretary. They are appearing in committee room 1. From the HSE, I welcome Mr. Liam Woods, national director, acute operations, Ms Angela Fitzgerald, deputy national director, acute operations, and Dr. Vida Hamilton, national clinical adviser and group lead, acute operations.

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

Members are reminded of the provisions in Standing Order 186 that the committee should also refrain from inquiring into the merits of a policy or policies of the Government or a Minister of the Government or the merits of the objectives of such policies. While we expect witnesses to answer questions asked by the committee clearly and with candour, witnesses can and should expect to be treated fairly and with respect and consideration at all times, in accordance with the witness protocol.

I invite Mr Breslin to make his opening remarks.

Mr. Jim Breslin: I thank the Chair and members of the committee for the opportunity to discuss the arrangement made with private hospitals in response to the Covid-19 pandemic. I note that the committee, in its invitation, indicated it was particularly interested in the use of the capacity of the private hospitals and the impact on continuity of care and treatment of private patients. Before I address these specific issues, I remind members of the context within which the arrangement was rapidly put in place.

The arrangement was concluded at the end of March, at a time when epidemiological projections for the disease indicated we faced a surge in cases with the potential to overwhelm our

health system. The European Centre for Disease Prevention and Control, ECDC, was clear that all European health systems faced such a risk at the time as we watched regions and countries struggling to manage. It was recognised that the HSE urgently needed additional acute hospital capacity to deal with the anticipated crisis and to protect other urgent time-critical emergency services.

On 16 March, the Government's action plan in response to Covid-19 identified the need to increase acute hospital capacity and so, on 30 March, following intense negotiation by the HSE and the Department, we reached agreement with the private hospitals. On that day, there were 111 patients with Covid-19 in intensive care units in our public hospitals. The figure had more than doubled over the previous week. The agreement, which has been laid before the Houses of the Oireachtas, gave the HSE immediate access to an additional 2,500 beds, over 100 of which were critical care beds, on a cost-only, open-book basis.

Thankfully, the public health measures adopted so assiduously by the public have meant that, so far, we have managed to suppress the virus and the anticipated surge has not occurred in the manner we all feared. On 27 March, NPHET recommended a pause in all non-essential health services. This was for the purpose of freeing up capacity and reducing opportunity for the spread of the disease. As a result, during April there were up to 2,000 public beds vacant at any one time, which is unprecedented. The level of patients in private hospitals was initially modest. However, the arrangement allowed the HSE to transfer and thereby maintain critical essential services, such as cancer surgery and chemotherapy, cardiothoracic surgery and urgent cardiology procedures, as well as providing the assurance that extra capacity was available in the event that it was needed, which was the main objective of the arrangement initially. Since then, local co-operation between the public and private hospitals has supported an increase in utilisation and the latest figures show that inpatient bed utilisation across private hospitals is now at 48% capacity and 56% of critical care capacity. The resumption of routine scheduled care has commenced and the HSE is continuing to increase its utilisation of private hospitals for the remainder of the period of the current arrangement.

The committee has also highlighted the issue of continuity of care. Faced with the immediate prospect of a major peak in demand for hospital care, the Government mandated the HSE and the Department to procure 100% of the available private capacity for public patients. The agreement provided that all patients treated under the arrangement would be treated as public patients, with care provided based on clinical priority. The arrangement made explicit provision for continuity of care for patients who were either in the hospital at the inception of the arrangement or who required treatment during the course of the arrangement. Full-time private consultants were offered locum public-only contracts for the duration of the arrangement. Where a consultant accepted the contract, he or she would continue to treat the patient but as a public patient. Where the consultant did not accept the contract offered, the transfer of the care of that patient to another consultant at the point in his or her treatment plan he or she reached was to be facilitated. Implementation issues were encountered and more generally, the pause in non-essential health services, which was only lifted by NPHET on 5 May, has affected private patients as well as public.

The Department worked with the State Claims Agency to make available clinical indemnity to those consultants who have not agreed to the contract, such as those providing care for continuity of care reasons to private patients on a *pro bono* basis, subject to the agreement of the hospital concerned.

The arrangement with private hospitals was developed in very quick order in exceptional

circumstances. It met its urgent objective of ensuring additional capacity was available in the event that the public system was overwhelmed and supported the maintenance of other urgent critical care such as cancer services. The public system faces ongoing challenges as we endeavour to resume operations in the context of Covid-19. The capacity within the private sector is an important feature of Ireland's healthcare infrastructure. It has a role to play in meeting the challenges we face in continuing to be prepared for any subsequent wave of the disease and for meeting ongoing healthcare needs. The Government is currently reviewing the current arrangement and as Deputies will be aware, on Friday, it announced that the current arrangement would cease at the end of June, and the Department and HSE were mandated to open negotiations with private hospitals to put an alternative arrangement in place.

Mr. Liam Woods: I thank the committee for the invitation to attend this meeting. I am joined by colleagues, Ms Angela Fitzgerald, Dr. Vida Hamilton and Mr. Ray Mitchell. I intend to go through a summary of the statement to allow time for questions. In March 2020, the Government approved a proposal from the Department of Health to allow for a formal partnership with private hospitals, which would make their facilities and capacity available to meet the challenges of the Covid-19 pandemic. This put more than 2,200 beds, approximately 8,000 staff, and a range of clinical facilities at the disposal of the public health service. A number of other countries have made similar arrangements, for example, the UK, Australia and Spain. By decision of the Government, the arrangement is now ending with a view to negotiating a new one going forward from the end of June.

The Government's decision to acquire access to the total resources of the private hospital sector included a number of key principles. The private hospitals would operate on the basis of public-only work. The basis for funding the hospitals was to be through a cost recovery model. Private hospitals would focus initially, at least, on delivering time-dependent care. Private-only consultants associated with the 18 private hospitals were to be offered temporary consultant contracts for exclusively public work. The public hospital system will continue to operate under existing eligibility rules. Clinical modelling exercises undertaken within the HSE in March 2020 regarding the expected demand for acute and critical care arising from the pandemic indicated that by mid-April we might possibly require up to 1,000 critical care beds and 2,000 additional inpatient beds to match peak demand. Existing public sector capacity was 250 critical care beds and 11,000 inpatient beds operating at close to 100% occupancy, with 650 unavailable due to delayed transfers of care. The timeline was pressing and the options available to ramp up short-term capability were limited. As a consequence, we secured the Government decision and agreement outlined above. On 27 March 2020, NPHET directed that "all non-essential surgery, health procedures and other non-essential services be postponed". As a result, all public and private hospitals curtailed their elective activity during April in the interests of patient safety and protecting capacity for surge requirements.

Approaches to boosting acute activity included stopping all non-urgent elective work, growing critical care capacity and acquiring private hospital capability. The experience to date has shown that private hospitals do not, generally speaking, employ the consultant specialists who work with them. They are served by either public appointment holders with private practice rights or by a group of "private-only" consultants who do not have public appointments. The number of private-only consultants is in the region of 550 and of these, 291 have taken up the offer of a public patient-only contract from HSE, a type A contract, and are treating public patients on the private sites.

A key concern identified was the imperative to ensure continuity of care for private patients.

The HSE fully acknowledges this requirement and where there is a justifiable case based on continuity of care needs, we have agreed that private-only consultant rooms can be included in the initiative as a recoverable cost. The HSE agreed a range of measures to ensure continuity of care, including private patients who were in a course of treatment at the date of the arrangement commencing continuing in care; patients who were booked for procedures based upon clinical priority being admitted as public patients without charge; some consultants offering to provide care *pro bono* to ensure continuity of care; and both the HSE and individual consultants having a duty to ensure care continuity, which has occurred. Additionally, consultants from public hospitals provided care in the private hospital setting and indemnity was provided.

Until such time as there is a vaccine or cure for Covid-19, healthcare delivery will occur in a higher risk environment where outbreak and surge could occur at any time. The underlying capacity issue remains in the acute system. This is amplified by the need to manage in a Covid environment. The private hospital system is not the sole solution for the safe delivery of care in the Covid environment but it is the only immediate acute option that can help provide an occupancy of 80% delivering on the twin requirements of matching non-Covid demand and providing surge capacity for Covid-19.

Against this backdrop, our objectives remain as set out earlier. These are to provide a capacity reserve against surge pressures, to maintain essential service to non-Covid but time-dependent surgery and treatments, to ensure safe environments for both patients and staff and to address the extensive build-up of displaced work as soon as possible. Some of the innovation undertaken in the past two months will need to stay in place. Virtual clinics can support the delivery of up to 50% of outpatient appointments in some specialties, reducing the requirement for face-to-face appointments.

In summary, all the indications are that the pandemic will remain a significant shaper of health services in the medium term. The basic shortfall in acute capacity is a matter we must address, along with Covid-19.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I apologise but I must interrupt Mr. Woods in the interest of time. I appreciate he was giving us a summary.

Mr. Liam Woods: Thank you.

Acting Chairman (Deputy Jennifer Carroll MacNeill): Members will have five or ten minutes for questions and responses from witnesses. We begin with Fine Gael members.

Deputy Fergus O'Dowd: I extend my deepest sympathies to the families and those who have lost family members as a result of Covid-19. It is very important that we acknowledge the pain and suffering of all those people, whether they were in public or private hospitals or nursing homes. All the people working in those facilities have put their lives and health on the line. It is very sad that thousands of people have caught this illness because of their work and commitment to people with the virus.

The expectation at the beginning of this crisis was that at the peak, in the worst scenario, 120,000 people per day could have been diagnosed with Covid-19. Was that the reason the Department of Health did the deal, which I fully supported, to take on 100% of the capacity of the private hospitals to deal with those potential patients if that apocalyptic number materialised?

Mr. Jim Breslin: Yes, very much so. It was not just that this was modelled. This was what we were actually seeing within our hospital services. I mentioned in the opening statement the

figures for ICU. Within the space of a week, the number of people in ICU had doubled to 111. The deal was done at 111. Over the next ten days, which was still within the incubation period for the virus, that number went up to 160. We were on a trajectory that was going to see ICU capacity run out. Two things happened. We took public health measures - the entire country took them - and assiduously implemented them to interrupt the virus. That managed to dampen the slope of the curve we were facing but we also had to put contingency in place and the most immediate and available contingency was in the private hospitals. There were 100 critical care beds in private hospitals and over the space of a weekend officials in both the Department and the HSE, with the full support of the Private Hospitals Association, put together an agreement that allowed the public access to those facilities if Covid-19 took us to the place none of us wanted to go.

Deputy Fergus O'Dowd: The actions the Department took were appropriate and fit for purpose if the worst that could ever happen did happen and that it was prudent and right that it did that. I want to make it exceptionally clear that I laud and support fully all the actions taken by the HSE and the Department of Health. That was acknowledged by everybody. The issue that arose here this morning was the spare capacity when that day did not come, thank God, due to the actions of the public, the health workers and all of us. When that did not happen, there was spare capacity in the public and private hospitals. As I understand it, on 27 March, NPHET made a recommendation that all non-urgent scheduled care be postponed both for safety reasons and to avoid the spread of Covid-19. In fact, a significant portion of the bed capacity that could otherwise have been used could not be used because of that directive. Is it fair to say that whatever issues are building up now in terms of backlogs, which are significant, are as a result of a medical opinion that the Department could not put patients into those beds? It was not the appropriate or proper thing to do.

Mr. Jim Breslin: We have to unravel two things that happened right at the same time. The underlying cause was the same but they were two completely separate things. Because of that exponential growth, NPHET took the public health advice that it would advise all non-essential healthcare services to pause. That included private healthcare. Public and private non-essential health services should pause. That was on 27 March and, on 30 March, the deal with the private hospitals was completed. NPHET made that decision for two reasons. The first was to ensure that we had space for the surge when it came but the second was in recognition that the spread of the virus within the community was such that there was a risk that bringing people in for non-essential healthcare would further spread the virus. Both public and private hospitals experienced that over the course of April. I mentioned in my opening statement that there were 2,000 beds vacant in public hospitals at one point, which is unprecedented. Undoubtedly, and there will be lessons to be learned for the next arrangement we enter into, there were complications in operationalising this arrangement. With 18 different hospital groups and more than 500 self-employed hospital consultants, there are many lessons to be learned but the biggest factor in the utilisation during the course of April and into the early part of May was that NPHET had not lifted the pause on non-essential healthcare during that period, which meant a lesser uptake of healthcare. In fact, when we surveyed the public during that period, 28% of people said that they delayed accessing healthcare during that period. We do not like that. We have tried to get the message across that they should seek healthcare but the public were naturally anxious about it, and both the public and private systems experienced that anxiety.

Deputy Fergus O'Dowd: The charge made is that it was not value for money but it was there if it could be used. That is the first point. The second one is that it was a value to the lives of all those people who could be put at risk if they caught the illness. That is why the criticism

is misinformed in that respect.

The question I wish to ask Mr. Breslin is one which affected some of my constituents, that is, the contract consultants were asked to sign. I appreciate and support the fact all work was public work, whether in public or private hospitals, and the income the consultant received could not be greater than the public pay. The question that arose, and it is a key point that must change, was what if I was an experienced consultant who might have 3,000 patients, and who had always maintained them with my own secretary or PA and in my own rooms? It is fair to say Mr. Breslin needs to look at that again should we have a return of this evil virus. Mr. Breslin needs to be able to meet the real costs of a consultant who has to manage his or her caseload. One consultant told me that it was like an iceberg. The tip of the iceberg was those in hospital but all the other people were outside. One has to meet them regularly and look after communications, appointments, and staff. Does Mr. Breslin think he ought to reconsider that issue now so that in the future, a consultant would be recompensed for those real, tangible, provable, additional costs that do not apply in the public sector? A consultant in the public sector has the back up of the hospital, he or she has administrative staff and so on. Does Mr. Breslin think that is an issue everyone could work on constructively?

Mr. Jim Breslin: If one looks at the phases of this arrangement, I would see plan A as when the surge was imminent. I would see plan B as being when that surge did not materialise, and efforts by the HSE to ensure we got other priority work through those hospitals. Plan C is from last Friday and where we are going to enter into negotiations on a new arrangement. The Government told us that plan A should be public only. The rationale was that if we all had the virus were we going to have different access depending on whether we had private health insurance or not? A legitimate policy rationale was provided at that time, and that is the arrangement that was put in place.

When we moved from the surge into essential and more routine treatments, one of the issues that arose was continuity of care for private patients. We were still able to tell consultants that those patients can be treated, but as public patients. Consultants then asked what was the position with regard to those rooms that bear costs and that they have to fund. We put an arrangement in place with the HSE whereby if those rooms were needed for the purpose of continuity of care, it could enter an arrangement to pay for them and have the use of them. This was very much as we moved along from plan A to plan B.

Where we go next will be plan C, which will be different. It will have a stream of public funds going in, but it will also see the private health insurance money come into play with the protection that if we have a surge we are able to take over 100% capacity again.

These are all decisions that are being made in real time. I do not see it as an issue that one changes one's position as something changes in the environment one is dealing with. It was the right thing to do at every stage.

Deputy Fergus O'Dowd: The question of IT was mentioned by one of the consultants in the mental health area. They do not have computers or technology. Can Mr. Breslin make sure that issue is addressed and does not continue to be the case?

Mr. Liam Woods: I will address the Deputy's question.

In terms of monitoring the work being done in private hospitals, the HSE with the support of the NTPF has put in a system for precisely that purpose. One of our early objectives was

to record the work that was taking place. We have enabled and supported that with the implementation of a system. Were there to be other system requirements as we move this forward, of course we will address those in dialogue about the arrangements post-June.

Acting Chairman (Deputy Jennifer Carroll MacNeill): Thank you, Mr. Woods. I will take Fianna Fáil now. Deputy Butler will be followed by Deputy Donnelly.

Deputy Mary Butler: We all understand the rationale behind the decision to take over the private hospitals at the start of the Covid-19 pandemic, however, as a committee the onus is on us now to look at the Covid-19 response and learn as we face the possibilities of a second surge. Mr. Woods referred to the fact there were 550 private-only consultants and that only 291 signed up. Many consultants who contacted me, and all the members of the committee, were disappointed that they were only offered a type A contract. Why was the option of a type B or a type C contract not offered?

Mr. Liam Woods: In the early stages of this, as the Secretary General said, the decision of Government was that there would be a singular response to what was a clear and pressing public demand, and that included a type A contract, which is a public-only contract. That is the contract the consultants I referred to signed up to. Signing it was voluntary of course, and a significant number of consultants chose not to do so. They had the capacity to continue their own outpatient practice outside of this arrangement.

Deputy Mary Butler: I thank Mr. Woods.

Mr. Breslin referred to the fact there has been learning for the next arrangement. Was any consideration given to the long-standing patients currently undergoing treatment and being treated by private consultants, especially those who need regular consultation? We have all been contacted by many private patients. We know there are 2.2 million private patients in Ireland at the moment, and many of them felt they needed ongoing treatment during March, April and May. I accept that it was an unprecedented pandemic, but at the same time many of these patients felt that they were forgotten about. I know all the focus had to be on Covid, and we all accept that, but as Mr. Breslin said, when we are learning for the next arrangement, could more consideration be given to these patients, especially those with oncology issues?

Mr. Jim Breslin: In my opening statement I referred to implementation issues which are available to us in constructing the next arrangement, and that we would learn from that.

I wish to emphasise that from the outset continuity of care was a really important objective of all of the parties that sought to make this work. It was provided for in the heads of terms with the private hospitals in two respects. On the day we entered into the arrangement there were patients in the hospitals, and it was important they had continuity of care. There were also patients who were undergoing a treatment plan with a private consultant, and the arrangement in that case was twofold. The ideal situation was the private consultant signed up to the contract that was offered on an agreed basis, in which case he or she could continue to see all of his or her patients under the new arrangement. The only distinction was that he or she could not charge the patient a fee, but that patient would still get continuity of care, and 291 consultants signed up. In the event that a consultant did not, a patient might wish to stay with that consultant. However, if he or she wanted, for example, to be admitted to a private hospital, he or she would need to be admitted under the care of another consultant. This would be either an existing public consultant, or one of those who had signed up to the private arrangement, in which case the patient's continuity of care would be facilitated by a transfer at the point in the

care that he or she was at - not going back to his or her GP and starting from scratch, but at that point in his or her care. Issues arose with that, but that was the clear objective we all sought to try to bring about.

Deputy Mary Butler: I thank Mr. Breslin. We learned from the opening statements that between 44% and 50% of private hospital capacity was utilised over the last couple of months. We learned last Friday that the arrangement will not continue. Are there any plans by the Department or the HSE to utilise as much capacity as possible during the month of June to tackle some of the extensive waiting lists that are out there?

Mr. Liam Woods: As the opening statements indicated, the decision of NPHET was effective up until 5 May, and from that time we have been growing throughput in the private hospitals significantly. At this stage, in terms of day care, it is in fact at 150% occupancy, so that is 1.5 patients per day, and in terms of inpatient beds it is at 50% occupancy. We intend to continue to grow that, and as part of the dialogue around any new arrangement, we would look to ensure continuity in relation to that. There is a clear intent to get value in the month of June. We will also remain alert to the trends that emerge in terms of the R-nought statistic as we move into the following weeks, and hopefully that remains where it is at a very low level. We need, however, to be alert to the fact that should the data move it will place significant demand on the acute system again.

Deputy Mary Butler: I thank Mr. Woods.

Deputy Stephen Donnelly: I would like to thank our witnesses. I will start with two questions. It was exactly the right decision at the start, but the secondary rationale, which was around maintaining capacity, has not worked at all. It should have been ended as soon as that became clear. At the moment, we are essentially using public money to treat private patients in private hospitals by private consultants. My first question is: why are we not using the public money to treat public patients with the spare capacity and letting the insurance companies continue to pay for the ongoing work for private patients which is still happening anyway? My second question is: why was the contract not ended sooner? I understand the contract was up until the end of June but all contracts can be negotiated by agreement.

It was estimated this morning in this committee that the ongoing reduced capacity in the private system just for June will mean that about 10,000 men, women and children will not get surgery under general anaesthetic, public and private. This is an enormous human cost for continuing with a contract that we know is not working. Did the Department engage with the private providers to see if the contract could be wrapped up sooner, given that it is not doing what we all hoped it would do?

Mr. Jim Breslin: On the first question regarding private patients, I go back to where we started from, which is that all patients were considered public patients. That is the legal position. Every person in the country is entitled to be first and foremost a public patient. They get to opt out of that and waive their entitlement if they wish to but all people, including those with health insurance, are entitled to be public patients. The-----

Deputy Stephen Donnelly: That really does not answer the question. I do not think there are not too many private patients in the country looking to waive their private patient status in order that they can become public patients and not get any treatment. The question I ask is: why not let the private patients continue to be paid for by the insurance companies, which is what would have happened, leaving all of the money to be deployed for use exclusively with

public patients?

Mr. Jim Breslin: What I was trying to go on to say was that that was the rationale of the arrangement I have called plan A, which was that of a single tier. Everybody in the situation of a pandemic would be treated based on clinical need and there would not be two streams of income going into the private hospitals, one from the public purse and one from private entities. The plan has changed and the Government on Friday opened up the possibility of us putting an arrangement in place where we would only pay for public patients.

Deputy Stephen Donnelly: I understand that. The question I am asking is: why? Mr. Breslin is restating what happened, which is everyone was to be treated as a public patient. I understand that. The question I am asking is: why? For people who get Covid, that decision makes perfect sense. For all of the ongoing treatment, however, if insurance firms are willing to pay for private patients - and perhaps they do not get priority during the crisis, I am all for that - why use public money to pay for non-Covid healthcare for private patients in private hospitals?

Mr. Jim Breslin: Let me try and give the Deputy further insight. There was the principle of the matter, which was that if we were facing the kind of overwhelming surge that was going to take place it should be public and single tier. There was also the practicality of the matter. None of us knew exactly what that would look like during the month of April. What was put in place was a cost-only reimbursement model, where the costs of the hospitals were reimbursed. The difficulty in that situation where one had cost recovery for all of the costs within a hospital of disaggregating how much of that was being incurred by private health insurers and private patients would have left us all with a situation where legitimate questions could be asked about whether the public money going in was benefiting public patients or cross-subsidising private patients who were continuing to have preferential access into what was now fully publicly funded facilities.

Deputy Stephen Donnelly: That might have been the concern people had but that is exactly what has happened. That is the entire point of my question. That became exactly what happened. Public money is being used. However, we are running out of time. Can I get an answer to my second question: did the Department engage with the hospitals to look at ending this earlier than June, given the vast human cost to keeping this contract in place?

Mr. Jim Breslin: I am not sure that the discussion this morning on the 10,000 fully appreciates how difficult it will be to bring either public or private facilities back up to normal levels. There is no doubt that there will be issues in terms of getting back to the activity levels we saw in the past, not just in the public system but also in the private system. I now turn to the Deputy's question as to whether that was done. The options examined were whether there would be an extension until the end of August, which would allow those negotiations to take place across June, July or August, or whether the HSE would terminate the arrangement at the end of June, leaving us with the next four weeks to put in place an alternative arrangement that would continue to see public patients access those facilities.

Deputy Stephen Donnelly: To be clear, nobody asked the private hospitals if they would be willing to continue until the end of June?

Acting Chairman (Deputy Jennifer Carroll MacNeill): We are at the end of Deputy Donnelly's time and I do not want him to take from Deputy Cullinane's time. Is Deputy Cullinane taking five or ten minutes?

Deputy David Cullinane: I will take ten minutes. I welcome Mr. Woods and Mr. Breslin again. I thank them and the staff in the HSE, particularly those working in the acute hospitals, for their service. I send them my solidarity at this time.

I read Mr. Breslin's opening statement with interest. Does he have the all-in costs for the private hospital agreement? Is there a figure available for that cost?

Mr. Jim Breslin: Mr. Woods will have the figures. We have the cost up to the current-----

Deputy David Cullinane: If we could have the cost first. I do not mean to be rude but if the cost is available, I would like to have it.

Mr. Jim Breslin: The Deputy can choose whether he wants the cost up to today or the projected cost to the end.

Deputy David Cullinane: I would like both, please.

Mr. Liam Woods: The cost until the end of April was €97 million. The cost is based on what work is actually getting done, so it will vary slightly. It would appear it will be between €97 million and €100 million per month. Those are estimates, whereas the first cost is a validated figure.

Deputy David Cullinane: Are we talking about a figure in the region of €300 million?

Mr. Liam Woods: Yes, that is right.

Deputy David Cullinane: Did Mr. Breslin hear the testimony from the Irish Medical Organisation, IMO, and the Irish Hospital Consultants Association, IHCA, this morning? To paraphrase the IHCA, the agreement was a bad deal, bad value for money and there was no plan for underutilised capacity. Having read Mr. Breslin's opening statement and heard what he said, I presume he does not agree with that statement.

Mr. Jim Breslin: I do not agree with it.

Deputy David Cullinane: Mr. Varley, the head of the IHCA, said, "the test of time has confirmed that the private hospital agreement, which is costing approximately €115 million per month, represents poor value for money from patient care and taxpayer perspectives". Again, I assume Mr. Breslin does not agree with that.

Mr. Jim Breslin: No. Can I tell the Deputy the reason?

Deputy David Cullinane: We will get to that in a second. First, I assume Mr. Breslin does not agree with that statement?

Mr. Jim Breslin: No, I do not agree with it.

Deputy David Cullinane: Mr. Varley then said "the private hospital contract is prohibiting the provision of urgent care required by patients with non-Covid illnesses". I have read Mr. Breslin's opening statement. He does not agree with that either.

Mr. Jim Breslin: No, I do not agree with that.

Deputy David Cullinane: We will return to the nuts and bolts of the agreement and how it was negotiated. Who was involved in calculating the cost and negotiating the deal on the State

side? I do not mean individuals, but what State actors - Departments and organisations - were part of the negotiation process?

Mr. Jim Breslin: The Government provided a mandate, a set of principles that would be used by the negotiators, and the HSE, with the support of the Department of Health, negotiated intensively with the Private Hospitals Association.

Deputy David Cullinane: It was negotiated by the HSE and the Department of Health. Who carried out the cost-benefit analysis if there was one?

Mr. Jim Breslin: There was input from across Government. The NTMA New Economy and Recovery Authority, NewERA, gave us some input, and the Department and the HSE looked at it. We came up with a cost-recovery model rather than a fee-per-item model. Part of the thinking was that there was so much uncertainty looking into April as to what services would be required. Had we got it wrong, there could have been huge profits-----

Deputy David Cullinane: Was a cost-benefit analysis carried out?

Mr. Jim Breslin: No, there was not a full cost-benefit analysis.

Deputy David Cullinane: There was not.

Mr. Jim Breslin: No, we did not have access to private hospital costs at that stage.

Deputy David Cullinane: As the party negotiating with private hospitals, I would have assumed the HSE would have sought those figures. Why were they not available? When we get into the nuts and bolts, the fundamentals of this deal, it was with private hospitals. Mr. Breslin will know, as he and I have soldiered alongside one another on the Committee of Public Accounts, that the Comptroller and Auditor General will always say that a cost-benefit analysis is hugely important when taking big decisions that cost taxpayers a lot of money. There may well be a good reason that was not done, and Mr. Breslin can answer on that, but what he is saying is that, as part of this negotiation, no cost-benefit analysis was carried out.

Mr. Jim Breslin: No, there was an options appraisal. We looked at different means of securing this capacity. A full cost-benefit analysis would ask whether we really wanted the capacity. That question was answered for us because we were staring our need for that capacity in the face every night on the 9 o'clock news. The next question was what were the options for securing that capacity. We did an option appraisal on the different types of options that might be needed-----

Deputy David Cullinane: I get that, so there was not one carried out.

Mr. Jim Breslin: -----and what was-----

Deputy David Cullinane: Could I ask if the Secretary General of the Department of Public Expenditure and Reform-----

Mr. Jim Breslin: If I could just finish, what was put in place then was a cost recovery model, where on an open-book basis the private hospitals have to produce their accounts to show that they have incurred the cost.

Deputy David Cullinane: Mr. Breslin has said that three times. I accept that, but what I am-----

Mr. Jim Breslin: The costs are then met by the HSE, and it is open to the Comptroller and Auditor General to audit those costs, as well as the HSE's advisers.

Deputy David Cullinane: Yes, that is the third time Mr. Breslin has said that. For the reason he outlined, there was no cost-benefit analysis, because, as he stated, the decision was made to do it, but there still could have been a cost-benefit analysis of sorts in terms of the fundamentals of the cost and I want to get to that.

Mr. Jim Breslin: Could I make one further point?

Deputy David Cullinane: Before I get to that, I am sorry for interrupting, but could I ask whether the Secretary General of the Department of Public Expenditure and Reform signed off on the agreement?

Mr. Jim Breslin: I would like to answer the last question that I did not get to finish. This was negotiated within a matter of days, basically over a weekend, and that is an important factor. The Department of Public Expenditure and Reform was involved in the submission to the Government on this. It supported the access to these facilities and it supported the cost-recovery financial model that was used.

Deputy David Cullinane: Did it sign off on it?

Mr. Jim Breslin: The Government signed off on it.

Deputy David Cullinane: Did the Department of Public Expenditure and Reform sign off on it? Did the Secretary General of that Department play any role in signing off on this?

Mr. Jim Breslin: The Secretary General or a Department are not independent of the Government.

Deputy David Cullinane: I know that. The national procurement agency is under that Department as well, and from other big projects where mistakes were made in the past, we know that the role of the Department of Public Expenditure and Reform is very important. All I am asking Mr. Breslin is whether that Department had a formal role in signing off on this process. If not, and it went straight to the Cabinet and it signed off on it, that is fine.

Mr. Jim Breslin: It did go straight to the Cabinet.

Deputy David Cullinane: So it did not.

Mr. Jim Breslin: The Department of Public Expenditure and Reform gave us its advice on the financial model and we adopted it. The advice was consistent with our own thinking.

Deputy David Cullinane: When Mr. Breslin was looking at this agreement, what percentage of capacity in private hospitals did he lock into the plan? What percentage capacity in private hospitals did he anticipate he would use over that three-month period?

Mr. Jim Breslin: That was the real uncertainty we faced. At the start we considered that we would probably need it all, and more besides.

Deputy David Cullinane: It was not all used, possibly less than half was used.

Mr. Jim Breslin: If we had had the ICU admission rates that other countries have experienced, we would have needed it all.

Deputy David Cullinane: In real time, is it correct to say that when Mr. Breslin was negotiating the deal it was on the basis that he anticipated using the full capacity in private hospitals?

Mr. Jim Breslin: We anticipated that we potentially might and we did not want to be in a situation where we did not have access to it.

Deputy David Cullinane: When Mr. Breslin was negotiating the deal, did he look at a like-for-like cost analysis of a bed, for example, in a public hospital and a bed in a private hospital? In terms of this particular deal that was negotiated, what was the average cost of a bed in a private hospital in the context of the deal which we now know will cost €300 million, and what was the average cost of a bed in a public hospital?

Mr. Jim Breslin: We do have average costs for public hospitals and based on the information we have from the private hospitals, quite a number of them would be more expensive than public hospitals, so we are paying more in that situation.

Deputy David Cullinane: But Mr. Breslin was negotiating the deal.

Mr. Jim Breslin: If the Deputy would give me a moment to answer, we did not have any other beds. We had all of the public beds that we needed. There were no other beds on the island that we could get access to, so getting it on a cost-only basis was the most economic thing for us to do. If there were cheaper beds out there, we could have got them, but there were not. These were the only beds that were available to us and we did it on a cost-only basis.

Deputy David Cullinane: I should point out to Mr. Breslin that on many occasions it was pointed out to him by all of the organisations that were here this morning and by people outside of this room as well that there was not capacity in the public system and that we needed more beds in the public system. The very fact that Mr. Breslin had to go to private hospitals is testimony to the fact that we did not have capacity in the public system. If Mr. Breslin is negotiating a deal, he is coming up with a price. I worked in the car sales industry at one point and if I was selling a used car I would have loved to see people like Mr. Breslin coming through the door. What I am trying to establish from him is whether, when he was negotiating the price, he would have had an estimated cost of what a bed costs in a public hospital, as opposed to what the cost was going to be in terms of this deal for private hospitals.

Mr. Jim Breslin: Yes, I have told the Deputy that. We would have had-----

Deputy David Cullinane: But the Secretary General did not give me the costs. What was the cost per bed, in terms of this deal in private hospitals compared to what it is in the public system?

Mr. Jim Breslin: We will not know that until we have all of the costs verified from the private hospitals. We are not paying them a fixed amount of money; we are paying them what they actually incur in terms of costs. The validation and verification process will be done by a team of accountants to come up with what that cost is.

Deputy David Cullinane: I accept what Mr. Breslin said that these were the only beds available and it was the obvious place to go for them. I am long enough around to know from my time as a member of the Committee of Public Accounts, and time spent looking at what is transparent, what should be accountable and what is value for money, that it is important to do a cost-benefit analysis and have the fundamentals of a deal properly examined. It does not strike me that that happened on this occasion. Mr. Breslin has given what he sees as logical reasons

why not but the fact is that the deal cost us €300 million. He said that he anticipated the full capacity would be used. However, less than half the capacity was used. I put to him again what was said by the Irish Hospital Consultants Association, IHCA, that this was not a good deal both in terms of patient care and taxpayer perspectives. It is hard to disagree with that given that there was no cost-benefit analysis and only less than 50% of the capacity was utilised.

Mr. Jim Breslin: To me, that sounds like a fire alarm went off and we sent four fire tenders to put out the fire and people are now saying we should have sent only three. I am very happy that we sent four fire tenders because what if it needed more than three.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I call Deputy Noonan and he has five minutes.

Deputy Malcolm Noonan: Now that elective surgeries have resumed and there will be a roadmap soon to outline the return to normality for healthcare services, it is important that both public and private open in tandem. Will the witnesses outline what elective services have resumed and give a breakdown of treatment as between private and public patients?

Mr. Liam Woods: The Deputy is right in saying that there is work going on in terms of a roadmap to recommence what were described as non-essential services, which are being resumed right now. In the public system there is a resumption of some activity. We have seen a significant fall-off in elective activity both by way of the decisions we have already spoken about and the public attitude to attending healthcare facilities. What we are resuming now is surgery such as orthopaedics. Rapid access cancer services continue to run and we are looking to grow the volumes through those. We have directly gone after growing the number of cardiology and stroke attendances because we have seen concern around that. General surgery, to the extent that we can resume it, is resuming. It is important to note, and it was referenced in dialogue, that the capacity to do work within the current environment is more restricted than it was before we had Covid, so our throughput capacities will be limited.

In terms of the private system, as referred to by the Deputy, the National Treatment Purchase Fund, NTPF, obviously has cases identified for priority treatment, and they can be and have been targeted through the private system. The private system is already doing cancer work for the public services. We had moved cancer work from the Mater Hospital and St. Vincent's University Hospital in Dublin. In Tralee, there is a joint roster working around key areas of provision in areas such as general respiratory care and rheumatology. We would anticipate that the caseload within the private system for surgery will also grow in the coming month contingent on what happens to the figures around the trend in the pandemic. The key point to get across is that the challenge of operating in both environments is very different from what it was if we go back three to four months.

Deputy Malcolm Noonan: Obviously it is not cost-effective to buy out private hospitals and consultants every time that there is a surge or another national medical emergency. What is the long-term plan to prepare for the next medical crisis?

Mr. Liam Woods: The next set of negotiations with the private hospitals, which are not the only response in capacity terms, and I can talk more about that, will be for a more medium-term view. We have to look at the coming winter, getting through that, the risks associated with Covid and flu being present and the demand on capacity, which we know is already constrained and, at the moment, is running at 92%. If we were to return all the work that is currently being done in the private system to the public system, that would immediately drive the public system

toward 100%.

In terms of strategies, we have to continue some of some of the innovations that took place while Covid was very present with us, and it remains so in areas like outpatients and emergency departments, to reduce, in effect, the footfall in hospitals and grow the amount of work done in the community in primary care environments. That will include the provision of diagnostic and other services in the community. We are also looking at a range of activities in what will be referred to as intermediate care - care provision between the GP and the hospital. They would very much be aligned with the kind of recommendations coming from the Sláintecare report. We are working to develop actively those kinds of arrangements right now.

Deputy Malcolm Noonan: I thank Mr. Woods. Is there a mechanism by which the HSE could transfer patients of consultants who did not sign the contract onto the public waiting list? What will happen to these patients when this deal is over?

Mr. Liam Woods: In the case of consultants who did not sign the contract, if there were patients who needed priority clinical care then that care was provided, very often by those consultants making arrangements with other consultants who had signed the contract. I have come across such cases. When the committee had the IHCA in this morning, it indicated that consultants acted in this way to ensure continuity of care.

Those patients who are already in treatment, in effect, will continue in treatment as a clinical priority. New private patients coming in will go onto a common waiting list by facility. That is the normal rule set within the system.

Deputy Malcolm Noonan: Have I time for a further question?

Acting Chairman (Deputy Jennifer Carroll MacNeill): Quickly, please.

Deputy Malcolm Noonan: The Government says the deal is ending but if there is another surge, it is extremely likely the private hospitals will be needed again. What are Mr. Woods's recommendations for ensuring continuity of care of both public and private patients and continued operation of general operational services should this occur?

Mr. Liam Woods: The key challenge for us is the demand for emergency care through the emergency department, which is by far the largest element of demand for inpatient care within our system. What happens that demand as we move towards winter is the key determinant of that. We have had to constrain elective capacity for reasons arising from the pandemic and we have also seen a fall-off in emergency attendances. As they return, and they are returning - those figures are rising which is a good thing - we have to plan on the basis that we need to retain some empty space to allow for safe care provision within hospitals. When we look to the future - the Deputy asked what the recommendations around that are - we must say what we need to do and what we recommend to keep the system at an 80% occupancy across the full system-----

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Mr. Woods. I will have to move on to Deputy Shortall.

Mr. Liam Woods: -----and what is the best use of the full-----

Deputy Duncan Smith: Deputy Smith.

Acting Chairman (Deputy Jennifer Carroll MacNeill): Excuse me, Deputy Duncan

Smith is quite correct.

Deputy Duncan Smith: No problem. I thank all the witnesses for their statements and contributions so far. I was taken with the penultimate page of Mr. Woods's opening statement, which states the HSE's "objectives remain as set out earlier; to provide a capacity reserve against surge pressures, to maintain essential service to non-COVID but time-dependent surgery and treatments, to ensure safe environments for both patients and staff and to address the extensive build-up of displaced work as soon as possible". Is it fair to say that the HSE would have liked to have seen this contract continue?

Mr. Liam Woods: As has previously been indicated, the contract was an emergency response to a rapidly emerging situation. It is right, as the Secretary General reflects, to think about phases. Flexibilities were deliberately included within the contract to allow for a review and a break at the end of June and further deliberation around that. From our point of view, it makes sense and we would welcome the renegotiation and working with the Private Hospitals Association around a renegotiated arrangement. It does not have to be precisely like this one but the capacity is clearly relevant as we move towards the winter.

Deputy Duncan Smith: The HSE essentially wants a renegotiated contract, a stronger contract. Although I do not want to put words in Mr. Woods's mouth, is he confident that as this contract runs down over the next few weeks, the pathways are there to use the capacity to a greater extent than it has been used thus far? How confident is he that the next contract will meet the needs of the HSE in terms of its relationship with the private hospitals?

Mr. Liam Woods: The occupancy has been growing, as I indicated in my opening statement and as the Deputy referred to. Since 5 May, when the NPHET decision was reversed, that has been a priority for us. The number of patients going through private facilities has been growing. We will look to continue that through to the end of June and, indeed, beyond based on a new arrangement.

The total requirement for healthcare is increasing. The Deputy knows that. That is clearly documented pre-Covid. Covid brings some new and urgent requirements around providing care. As we look forward in the HSE, we are looking at the winter. In any event, we are looking at a time period that goes beyond the end of August. We have got to look through to March next year and make sure we have plans in place to address what will happen over the coming winter.

Deputy Duncan Smith: Would the HSE be in favour of purchasing one or two private hospitals? Would that not be the quickest way to get more capacity in the public setting? Has that been discussed? Has it been costed at any level by senior management in the HSE?

Mr. Liam Woods: I have not been party to any dialogue about the purchase of private hospitals. The fastest way for us to respond to the pandemic was to get access to use these hospitals, which was done through a cost-based arrangement, as was previously discussed. The notion of acquiring private hospitals was not part of our early discussions because time was not our friend in putting arrangements in place at the end of March.

Deputy Duncan Smith: Has any indication been given to the public as to when screening services will come back? Will they use the capacity available during the last few weeks of this current contract or will they form part of the renegotiation with the private hospitals for the next phase? Can any information be given to people who are looking for these services?

Mr. Liam Woods: They are not directly connected. The Deputy's point is well made. It is

a priority for the HSE to recommence screening services but they are not tied into the hospital arrangement. There are other clinical priorities in respect of the return of screening. Our chief clinical officer has addressed these previously. Our priority is to make sure that it is safe to resume screening services but this is not tied into the private hospital arrangement. That is about planning services in the new Covid environment. The return of screening services is a priority for us.

Deputy Duncan Smith: Finally, what is the current status of the arrangement with Citywest Hotel? Is it being used to its full capacity? I know it is not a private hospital arrangement but it keeps cropping up.

Mr. Liam Woods: There are two dimensions to the Citywest arrangement. Accommodation is being provided for staff members and patients in the hotel. This accommodation is occupied. I do not have the level of occupancy in my head but it is occupied. Separately, the conference centre has been set up as a facility with more than 300 beds. This was put in place as surge capacity to meet what was then an unquantifiable demand as we moved towards the peak in the middle of April. At the moment, that facility is being closely studied with a view to opening it for clinical purposes associated with post-Covid treatment and rehabilitative care. We are also thinking about using the facility for outpatient treatment because the space required for outpatients in the future will be much greater than what we have, even with the heavy use of virtual clinics. More than 80,000 virtual appointments were completed in the month of April.

Deputy Duncan Smith: I thank Mr. Woods and the other witnesses. We are delighted that four fire engines were sent to deal with this crisis rather than three.

Deputy Róisín Shortall: I join with Deputy Duncan Smith's comment with regard to fire engines. I thank the witnesses for their presentations. People have spoken about lessons learned. The bottom line in all of this is that our public health capacity is woefully inadequate. Responsibility for that is entirely political.

I have two questions. The first is for Mr. Woods and the second for Mr. Breslin. It has been possible to use capacity for non-Covid cases since 5 May. The HSE seems to have been very slow in ramping up the use of that capacity. I know there was some initial reluctance and people were concerned that a surge would arrive - and I am thankful it did not - but, at the same time, many procedures could have been carried out. I am referring to hip and knee procedures, for example. People could go in for two or three days and be back out. In the event of an increase in Covid cases, the hospitals could have been cleared very quickly. Why are we so slow in ramping this up? There are just over three weeks left to run in the current contract and there is still no roadmap. That is very hard to understand. There is very valuable capacity in private settings and, to a certain extent, in public settings. Why are we not maximising the use of this capacity? That is my question for Mr. Woods.

My second question is for Mr. Breslin. It relates to the future. Many of us would have liked to see the contract continue even up to the end of the year and the capacity be used fully. All Covid patients got immediate access. There was no distinction made between public patients and private patients. There is a strong case to be made for continuing with such an approach for non-Covid cases. Sláintecare talked about the importance of elective-only hospitals. That has been accepted by the Government. Has the Department of Health considered designating certain private hospitals as elective-only hospitals and, in this way, really motoring through elective surgery waiting lists and making progress very quickly? Has the Department looked at the possibility of taking over those private hospitals on a longer-term basis, as has happened

in Scotland?

Mr. Liam Woods: I will address the first question on capacity. Since 5 May the priority has been, as the Deputy has indicated, to use the capacity to the greatest extent possible. In day-case care, it has worked well with occupancy at 150%. On the inpatient side we are now at 54%. It is our intention to grow that. It has been growing, it has come from approximately 40% to 54%. We are seeing progress but would like to see more of that. One critical factor for effective use is the time it now takes to schedule a surgery and post surgery to ensure appropriate procedures are in place around infection prevention and control, which is having a significant impact on throughput. The time to operate, for example, is leading to places like the Mayo Clinic in the US having 60% occupancy. We are at 54%. Normally private hospitals run at around 75%. Our objective is still to push that occupancy figure as high as we can by using NTPF-referred work and by transferring work from the public to the private system, which I spoke about earlier. We will do everything we can in the coming weeks to optimise that. This will inform partly our dialogue around the new arrangements.

Mr. Jim Breslin: On the question about elective procedures only, and building on Mr. Woods's comments, under the new arrangement we would focus on elective. Some, such as cancer care relocations, would be separate but by and large we would focus on elective. I believe the meat of the question Deputy Shortall has asked relates to a project we have under way under Sláintecare, where we have fully mapped and assessed the needs of service delivery mechanisms that would say "Here is the service output we need for Dublin, Cork and Galway". We have also looked at other parts of the State but these are the three areas mentioned in the national development plan. We are now at the phase of moving that into a facility requirement. We will then put a cost on that facility, that is, were we to deliver an elective hospital at that scale for those services, what would be the facility required and what would it cost? Then we would get to the point of making a question to the market as to whether it would be a new build or a purchase. I am agnostic on that but it is important that we do the work over the next few weeks to get us to that point.

Deputy Róisín Shortall: Will Mr. Breslin confirm that purchase is under consideration, or is on the table at least?

Mr. Jim Breslin: It will be one of the options, yes.

Deputy Richard Boyd Barrett: Would Mr. Breslin accept that we are caught on the horns of a major dilemma here, where one is damned if one does and damned if one does not, arising from the fact that on entering into this crisis we had woefully inadequate levels of capacity in intensive care units, ICU, beds, staff and consultants? That is the fundamental problem. It was unacceptable, on entering into the crisis, that we were already operating at near to 100% capacity, and were sometimes overwhelmed during flu season. On top of this, for the foreseeable future, there is an additional care need around a pandemic that could surge at any point in time. Unless we dramatically ramp up capacity we could be in deep trouble in the near future.

Mr. Jim Breslin: Broadly, I would, but we are all a bit Irish whereby having got through this, we look back and say "We must have been lucky". We were not lucky with the amount of capacity we have. We knew that we had less than the international norms of ICU. We also knew in other areas that we were short, and yet we got through it. It is worth asking how we have managed. It is the quality of the staff, the performance of people on the front line, and the absolute commitment that people have given to that, including those in the HSE and I might even mention the Department and the Oireachtas in that regard. We did manage to do some-

thing right.

Deputy Richard Boyd Barrett: I do not dispute that. We accept there is an unacceptably low level of capacity given the pre-existing challenges pre-Covid-19, and now with Covid-19.

As a sidebar, I will turn to the heroic work of our health workers. Are the high infection rates in any way linked to the low staffing and capacity levels, which meant staff were overworked, working excessive hours and therefore exposed more to the virus? It seems to me that there is a connection. Some in this House have made it clear that they want to return essentially to the two-tier system and give the capacity back to the private health system. Is that not reckless in the extreme given that we could face surges in the near future? With the limited capacity we have, do we not at least require a totally integrated system rather than a fragmented one? That means keeping the private capacity under public control. I think that is what we must have. Has Mr. Breslin considered the outright nationalisation of the private hospitals rather than paying them rent of €110 million a month, which is clearly not very good value?

Mr. Jim Breslin: Certainly given that we do not have a vaccine for Covid-19, I think all of us would want to have step-in power or retainer over the private hospital capacity so that if we did get the kind of surge that we fear, we would be able to move quickly. We would also want to have access to the capacity for priority needs. I think the Deputy is bringing me into the policy space when he asks me about nationalisation. What I can say to him is that the Department of Health completed a bed capacity report which found that if we do all of the reforms that are in Sláintecare and all of the changes that we need to reform and modernise our healthcare services, we will need 2,500 beds. We have probably delivered about 500 of them since that report was completed. If we do not achieve that reform, we will need 7,000 beds. It is well known that we are short of capacity.

Deputy Richard Boyd Barrett: Fair enough. Given that we have to increase capacity, would it not be helpful if, for example, the Department did not have to negotiate with private hospitals but just had the capacity? Would that not be better? It would be better if we knew what was on their books, which we do not really know, in terms of the cost of beds. Would that not be better notwithstanding the need to ramp up capacity? One of our earlier witnesses, Professor Alan Irvine, suggested that we should be looking at local solutions to quickly ramp up capacity. Are we doing that? For example, there are two buildings of 17,000 sq. m near Merrion Gates called the Seamark buildings. They are sitting empty for the last five years, right beside St. Vincent's Hospital. When there is talk of setting up modular hospital beds, would we not be better going in and purchasing those blocks for increasing capacity on an emergency basis? That is just by way of example.

Mr. Jim Breslin: I do think it depends on the timeframe we are looking at. We talked earlier about the purchase of a hospital, if one has a year or two. We had days at the start of this arrangement and the quickest and easiest way was by agreement with the private hospitals, which thankfully we got and they came forward on that. The other options such as purchase, nationalisation and so on bring one into a much more convoluted policy development and legal process. Mr. Woods has talked about the bespoke solutions that are available at different sites in the public system, which we have been pursuing in parallel with this. I will not commit to making an offer on a building on the Merrion Road but each hospital is looking at its ability to surge and introduce new capacity as part of this.

Deputy Matt Shanahan: I have a couple of comments for Mr. Breslin. In respect of his comments about four fire tenders being sent out and are we not glad that we sent them, I would

agree with him but I would also say that pretty soon we discovered that two fire tenders had the fire under control. We could have sent those other tenders off to treat fires elsewhere. In other words, the under-capacity was recognised yet nothing was done about it. Mr. Breslin said earlier that a partnership arrangement was entered into with respect to the private hospitals and the consultants. I note that the IHCA wrote to the Department at the end of April outlining the capacity issues and the fact that there was between 20% and 30% capacity being used. What steps did the Department implement at that stage to try to recover some of the cost? What is at issue here is public money. This is what people are questioning, especially considering the timeframe we are now going into and the costs we are going to see as a result of all of this.

Mr. Varley outlined in committee earlier that he learned in the media that a type A contract was to be introduced for doctors. He also learned that indemnity insurance might be removed. I am not sure that is a partnership arrangement I would want to enter into. Will Mr. Breslin give a response to that?

Mr. Jim Breslin: On the first question, as I said earlier, we moved rapidly through different plans. When we started off, a surge had to be planned for. When that did not materialise, the heads of terms had already provided for further, non-Covid activity that could take place in those private hospitals, and the focus of everybody's effort was to promote that. People keep forgetting, however, that between 27 March and 5 May, NPHET had said routine healthcare services should be paused. It was against that backdrop that we were working.

On utilisation and the IHCA, I will not speak for everybody in the room but I think we have, collectively, spent many weeks of hours trying to engage with the IHCA to try to find a way through that would unlock the commitment of private consultants, about 50% of whom signed up pretty readily but quite a number had significant concerns. We clarified at length, and while we were not in a position to give them what they were looking for, we certainly gave them clarification over a protracted period in the hope that as many of them as possible would come on board. It was a voluntary arrangement and more and more came on as it continued.

Deputy Matt Shanahan: I am not sure whether there is an ideological block here. On 8 May, a letter from the State Claims Agency, signed by a gentleman with the initials "C.B.", instructed pathology labs not to process specimens unless the sending consultant had signed a type A contract. How does that fit into public healthcare and cover?

Mr. Jim Breslin: There are two points. That was in a situation where the public purse was paying for the full running costs of the facilities, and the person who signed the letter issued it on that basis. Within 24 hours, that was clarified and arrangements were put in place to facilitate that.

Deputy Matt Shanahan: With respect to the payments, in the period of the three months the premium income that will have been paid over to private health insurers is approximately €700 million. The rebate that has come back is about €180 million. That is €520 million of moneys that could have been put into the private hospitals to take account of the efficiency that was there, aside from the fact that consultants were essentially blocked out. I am all in favour of a single-tier health service but the issue is with efficiency and costs. It has to be questioned how we put a contract in place for €115 million a month, yet we were working off bed capacity of 20% or 30% and elective capacity that fell way short of that, particularly in the early months.

Mr. Jim Breslin: I ask people to reflect on the fact that there was a public health restriction on the operation of our healthcare facilities. It is not the whole explanation but it is an

important contextual factor for why all of our hospitals were not as busy as they are in normal times. People have associated the impact of that with the arrangement with the private hospitals. There is no doubt there were challenges in the arrangement. It involved 18 hospitals and more than 500 independent hospital consultants, and arrangements had to be made in each of those instances-----

Deputy Matt Shanahan: Will Mr. Breslin give a commitment now, in this contract, to finding a way or mechanism to get all these doctors back in, in order that we can get maximum efficiency through both the public and private space?

Mr. Jim Breslin: We will work to a mandate the Government has provided to us, namely, that we will seek to put a retainer in place for capacity to surge if those facilities are needed and that we will put arrangements in place for particular cohorts of patients to be treated, but it will not require 100% of the facilities of the private hospitals. That is the policy mandate we have been given.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Mr. Breslin-----

Deputy Matt Shanahan: With respect, these are elective procedures.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I am sorry but Deputy Shanahan is out of time.

Deputy Matt Shanahan: The private hospitals should be directed to give up their bed capacity within 48 hours, so we will not need to focus on this for months at a time.

Deputy Michael Collins: I welcome our guests. Two months ago, on 1 April, the HSE took over all of our private hospitals in a bid to be prepared for a surge of Covid patients, as had happened in Italy, Spain and other countries throughout the world. While it was very important to put these contingency plans in place, thankfully they were not needed. As a result of the two-month shutdown of normal services, the HSE is now trying to cope with the thousands of patients on waiting lists whose appointments were cancelled due to Covid. The deal between the HSE and the private hospitals will not end until the end of June, by which time the waiting lists will have become longer. One Galway oncologist recently stated he had 60 cancer patients on a waiting list and 3,000 active cancer patients on his room list. These, he said, were patients he had treated in the past who may be having a relapse during the shutdown period. This three-month delay has affected cancer patients, orthopaedic surgery and all routine elective inpatient day-case and outpatient procedures which were halted on 1 April to free up space for the feared spike in Covid patients. We are all well aware that delays in biopsies, early access and treatment are likely to have consequences for patients. This could mean loss of life. It is a serious issue for all cancer patients, be they public or private. All cervical screening has been paused in the past two months. Now we have a significant backlog which will not be cleared for months, maybe even years.

Why could laboratories not have processed these smear tests in tandem with the Covid testing, thus minimising the risk to women's lives through early detection?

Mr. Liam Woods: The laboratories in hospitals continued to operate and did perform tests. Were cancer tests required through, say, a rapid access clinic, they were happening. The point the Deputy is after is for screening which can give rise to tests. The screening had been paused. That was a real effect. As I said earlier, it is a priority to get that back and running in a safe way.

Deputy Michael Collins: As I understand, private hospitals are lying idle while patients' appointments have been put on hold. In addition to that, patients were advised to stay at home which meant cancer patients missed treatments while oncologists' waiting lists grew longer. Several of my constituents told me that their appointments had been cancelled with no idea of when they are likely to be rescheduled. Now that the number of deaths from Covid has, thankfully, fallen significantly, as well as a dramatic fall in new Covid cases being recorded, will the private hospitals have to wait until the end of June before they start seeing patients again?

Mr. Liam Woods: No, they will not. Private hospitals are seeing patients now, as we discussed. I think the Deputy is referring specifically to delays in access to outpatients. I would remind him that half of all pure private consultants, of which it is estimated there are just under 600, are not part of the arrangement. They presumably are seeing their patients.

The other consultants who have signed into this arrangement can see their patients in the context of the heads of terms in place. Accordingly, there is not a reason why there is an incapacity to see patients. There is a disruptive effect of Covid, to which the Deputy has referred. That has had an impact, both on patients' own choices and on service provision in the recent period. As the Deputy rightly said, in the public system, where there are 3,200 consultants, our experience has been that there has been a significant fall-off in both outpatient and emergency department attendances. These are now, thankfully, returning to more normal numbers. The key point is that, in advance of this arrangement coming into place, there was a significant fall-off in both public and private systems as the impact of Covid came more into the public consciousness and impacted hospitals.

Of course, our priority is to use the remaining period of this arrangement and the wider public system, which has 11,000 inpatient beds within it, to provide the services that need to be provided. A major challenge for us, not just in cancer care but across all services, is to catch up with what have been growing demands for care, as well as a pent-up demand for access to outpatient and inpatient care.

Deputy Michael Collins: That leads me to my next question.

Although the intention is to return to a full healthcare system as quickly as possible, it is fair to say we had extensive waiting lists in all our hospitals, both public and private, before the Covid crisis. Considering all the extra precautions which will inevitably have to be taken to ensure social distancing, along with safety measures to ensure patient and staff safety, what plan has the HSE proposed to deal with the enormous waiting list for all types of necessary procedures while ensuring the safety of all involved?

Mr. Liam Woods: It is important to return to a level of service provision, which probably will not be at the pre-Covid level but will be greater than we have seen in the past couple of months. The future of this arrangement with the Private Hospitals Association will also be important in terms of work being done. However, the workflow through the emergency departments, the biggest piece of inpatient work in the HSE, and what happens with that as we approach winter will be of critical concern. An environment in which we have capacity constraints - and as the Deputy indicated additional capacity constraints around safe practice in a time of Covid - is going to present a big challenge. The negotiations with the Private Hospitals Association, in accordance with the Government's decision, will be an important piece of that. There are other elements, to which I referred earlier, around intermediate care at which we are also looking.

Deputy Colm Brophy: I thank the witnesses for all their work to date, and I thank all the staff in our health service, including the HSE, for everything they have done. When I sit here, I sometimes think I live in a parallel world where some of the questions the witnesses are asked seem to be classic Monday-morning quarterbacking. I cannot imagine what situation this committee would be in today if the private hospitals had not been secured, and if capacity had not been secured and we had needed it. I fully support and acknowledge the deal done. It was the right thing to do at the right time. Tremendous credit is due to the witnesses for representing the State on its side of the argument. The private hospitals weighed in quickly enough to put the deal in place. It is easy now for some Deputies to say what they are saying. They seem to sit back and discard the extent of the achievement of the public, through its actions, in flattening the curve and preventing the circumstances we were rapidly heading towards, which were evident in Madrid and Milan. It does us a disservice as a committee not to acknowledge the type of work done.

I want to return to one or two points. The witnesses' fire brigades were well needed and well wanted. I would not send any of them away early; that risk should never be taken. The witnesses, particularly Mr Breslin, were asked a certain question on which they were not really given a chance to reply. The deal was called a bad deal. Mr Breslin said it is a good deal. Why is it a good deal?

Mr. Jim Breslin: It was primarily for the reason the Deputy just mentioned, that is, that it was contingent on our being overwhelmed and the view that we would have the capacity if overwhelmed. We will never be able to value that. Regarding the actual valuation and the cost–benefit analysis - I have done such analyses in my time – I do not know how a figure could be put on it. Capacity was the primary purpose of the deal. We moved to plan B when what was envisaged did not emerge. It is not that it did not emerge on 1 April but that it did not emerge over the course of April. We worked based on what had already been written into the heads of terms, namely, that we could prioritise other essential care and other non-Covid care. The HSE put arrangements in place to try to boost that. Getting that activity through was not easy because it was in circumstances of public health restrictions, nor was it easy because we had moved into an operational environment in the private hospitals that was completely new by comparison with anything the HSE was used to. We have, however, seen a steady use in the utilisation of the facilities.

Deputy Colm Brophy: That brings me to a point I want to make. I am so conscious of time. Obviously, people seem to have forgotten again that there was a pandemic raging. We were told we could not use our hospitals by NPHET. One cannot be blamed for adhering to public health advice. We need to be conscious of the fact that members of the public, including my family and others I know well, were choosing to avoid going to hospitals if they could. This was not based on good medical choice. We forget so quickly that at the stage we were at a few weeks ago, people would not have accessed a medical facility even if there had been all the capacity in the world because they were genuinely terrified. "Terrified" is the right word for it. Thankfully and gratefully, because of what is happening now in our country, a certain level of normality is returning, and we are seeing that capacity.

I agree that a cost–benefit analysis could not have been achieved when trying to do a deal so fast. Does the open cost Mr. Breslin has for the private hospitals reflect the capacity level at which they are being used?

Mr. Jim Breslin: Yes.

Deputy Colm Brophy: In effect, therefore, we are getting good value for money in the deal. We can see what the costs are and we are paying for what we use. We are not actually paying more because they are at 50%, 30% or 20%; we are paying exactly the amount that relates to what we use. Indeed, if one ramped up capacity, would there not be a surge? I wish to understand this clearly. Are we paying for what we use?

Mr. Jim Breslin: Yes. We are paying actual costs. That is not me saying more activity could not have been pushed through and that it would not have been worthwhile. We were all looking to do that. However, what we are actually paying is the actual cost incurred. If a lower cost is incurred due to less activity, we pay less money across.

Deputy Colm Brophy: Regarding the new deal, I am interested in knowing Mr. Breslin's estimate if the private hospitals are working at a reasonable capacity - 75% of normal capacity or whatever. If an emergency was declared due to a surge, what do the Department, HSE and State bodies think about how quickly private hospitals could be converted back to deal with the surge?

Mr. Jim Breslin: The quick answer is that it would take days. We will need to model it but it would take days because of how quickly exponential growth can take off and, secondly, because private hospitals would need to be decanted. One would not want patients in them. One would need to run that down over a number of days. I think it would take days rather than weeks.

Deputy Norma Foley: I welcome the witnesses and thank them for coming. I acknowledge the superb work of our healthcare staff and the gratitude we owe to them. Without a doubt, it was the right decision at the right time to take over the private hospitals. We have to be honest and fair and say that. However, as time progressed, it was clear that the full capacity of private hospitals was not required. The decision has been taken to terminate that contract but there is an acknowledgement that a new contract will be required if, unfortunately, another surge occurs, although we hope it does not. Who will be party to the negotiations for that contract? We heard deep disappointment this morning and indeed an acknowledgement that it would have made the situation less fraught if the consultants were also around the table with the private hospitals to address that. Will the consultants be party to those negotiations? What timeframe do the witnesses envisage to complete those negotiations? I acknowledge that it was terminated last Friday.

Mr. Jim Breslin: On the State side, the HSE will be the contracting authority and the Departments of Health and Public Expenditure and Reform will participate in the negotiations. The negotiations will primarily be with the private hospitals. The National Treatment Purchase Fund has an arrangement to pay for the services of private hospitals. This was a novel situation where we were trying to convert private hospital consultants into public employees and there was a need to engage with them. We will engage with private hospital consultants but I envisage that the contract will be with private hospitals in this case. Regarding how long it will take, contact was made with the Private Hospitals Association on Friday. We have agreed to come back to it later this week with the type of proposal we might seek to bring forward. We would hope to have quick negotiations over the course of the next couple of weeks to try to conclude this in good time for the run into the end of June.

Deputy Norma Foley: I thank Mr. Breslin. I appreciate that time was not on his side for negotiations previously. To my mind, it would make matters less fractious in future if consultants were part of the discussions from an early stage. I have a question relating to a point that

was previously raised about the fact that no pathology specimens could be processed unless the sending consultant had signed a type A contract. I appreciate that Mr. Breslin says that was rescinded within 24 hours. Mr. Breslin suggested the motivation for that was financial. Will Mr. Breslin confirm that no patient was negatively impacted because of that original decision? Will he confirm that this will not arise going forward in the new contract, regardless of the financial or other implications? Is he in a position to tell us who actually directed that? Who made the decision in the first place?

Mr. Jim Breslin: I was not involved in the events that gave rise to that. If I get it wrong, maybe somebody here could clarify it for me. I do not see it occurring in the future because any future arrangement is unlikely to entail 100% control of those facilities, which means the private hospitals will still be able to do work outside of the arrangement with the HSE. Given that it was rescinded within 24 hours and it related to laboratory requests, I do not envisage that it had any significant impact beyond 24 hours of disruption. I cannot see how it could have interfered with a result. I cannot see how that could have happened.

With respect to how it came about, much clarification was being sought in what was a complicated position around the extent to which clinical indemnity, which is a State insurance or indemnity scheme, covered certain aspects but did not cover other aspects. The communication that issued sought to clarify the matter but left one piece unresolved. When it was seen, it was addressed within 24 hours.

Deputy Norma Foley: I have a final question. Both the witnesses indicate private hospitals are running at a much higher capacity now even in terms of operating theatres etc. Is that because public hospital theatres are also running at full capacity? Are they both running at almost full capacity at this stage or has some capacity in the public hospitals been stood down?

Mr. Liam Woods: The public system is returning to theatre activity but it is not yet at full capacity. The additional ICU beds that have been stood up in the public system are heavily dependent on theatre and nursing staff to sustain them. Part of the return to normal theatre will arise from being comfortable that ICU capacity that has been stood up on a temporary basis is safe to release.

Deputy Louise O'Reilly: I thank the witnesses and everybody involved for their ongoing work. We fully appreciate how difficult this is for everybody involved and we know the effort that has gone in to date and which continues. It is possible this could be taken as a given but it is still important to say it nonetheless.

My first question relates to the value-for-money element that is clearly absent from this entire exercise. There was no value-for-money analysis or cost-benefit analysis, from what I can gather. What kind of economic analysis was done? There must have been some. We were talking about spending a large amount of money and Mr. Breslin's Department has frequently had to answer in public about what is perceived by some as being a waste of public funds. Clearly some economic analysis must have been done on the level of money being spent. To what extent was economic analysis done, who conducted it and will the witnesses share the findings with us?

Mr. Jim Breslin: Different economic analyses were done and both the HSE and my Department did financial analyses. We took advice from NewERA, which is part of the National Treasury Management Agency. As we were dealing with the private sector and a commercial sector, we specifically went to NewERA to see what would be the approach. In each case we

looked at different options for reimbursement mechanisms. For example, we could have used the National Treatment Purchase Fund schedule of fees but we chose a cost recovery model. Had we used the National Treatment Purchase Fund schedule, there would have been a very significant level of uncertainty because we were not able to specify in advance the schedule of services that we would need over the course of April. It was just too unpredictable. The model we went with, based on all that option appraisal, was the cost recovery model. The HSE has independent advisers in operating that model to validate and verify costs before final payments are made.

Deputy Louise O'Reilly: That is before final payment but I presume it is after the money has been spent.

Mr. Jim Breslin: The money is spent------

Deputy Louise O'Reilly: Will Mr. Breslin share that information?

Mr. Jim Breslin: Sorry, we were talking over each other. The money is advanced and a reckoning is done based on accounts, with a balancing payment then being due. I did not hear the Deputy's question.

Deputy Louise O'Reilly: We will not know the cost of this until long after this deal concludes. Is that right?

Mr. Jim Breslin: We will not know the final cost but the validated costs have come in below the estimates provided by the private hospitals. To that extent the figure has come in lower than initial estimates.

Deputy Louise O'Reilly: We still do not know the final costs, so the figure could be higher in the end.

Mr. Jim Breslin: I do not think that is likely.

Deputy Louise O'Reilly: We do not know that. Is it possible for Mr. Breslin to share the information in the economic analysis?

Mr. Jim Breslin: We can provide the analysis as long as there is no commercially sensitive element. I do not believe there is.

Deputy Louise O'Reilly: Okay. I heard the witnesses earlier compare this to making sure four fire tenders would be available. If we wanted a complete picture, we could say the conditions were created in advance for the fire to get out of control. That is the reason all of the additional capacity was needed. We had that discussion with the representatives of doctors and consultants this morning. On 24 March, an announcement was made by the Minister for Health that capacity had been secured in the private hospital sector. However, the deal was not signed for another week, either on 31 March or 1 April. Who was involved in the negotiations during that week? Were only officials from the Department of Health and HSE involved or were officials from the Office of Government Procurement, OGP, involved as well?

Mr. Jim Breslin: It was the HSE and the Department of Health throughout that weekend. I think it was concluded on 30 March.

Deputy Louise O'Reilly: There were no officials from the OGP or the Department of Finance involved at that stage.

Mr. Jim Breslin: No. We had a mandate from Government and we had to get the approval of both the Minister for Health and the Minister for Public Expenditure and Reform for the final agreement.

Deputy Louise O'Reilly: Was a maximum price set at that stage, given that the announcement had been made? Reference was made earlier to whether this deal was good value for money, and I believe that is what people want to know. In making the announcement when the deal had not been concluded, the officials did not put themselves in a great position to do a deal that was good value for money. I say that notwithstanding that I and others welcomed the decision to make the additional capacity available. We all have a view on the reason that additional capacity was so desperately needed. Watching what was happening in Italy, we could see that our hospitals could very easily become overwhelmed given the conditions that had been created. Does Mr. Breslin believe he was hamstrung somewhat in the negotiations during that intervening week by the fact that the announcement had been made but the deal had not been done?

Mr. Jim Breslin: No, I do not. The private hospitals knew what we were seeking to achieve. There was no way we could have done this in secret. We could not say that we wanted immediate access to all of the facilities of the private hospitals in the State and for them not to know that was something that we really wanted.

Deputy Louise O'Reilly: I am not suggesting that it could have been done in secret. What I am suggesting is that going out to make an announcement before the actual deal was done would have hindered Mr. Breslin in getting good value for money. It has become very apparent that value for money was not an issue. We will not know the final cost of this, and I think that will be fairly worrying for many people.

With regard to-----

Mr. Jim Breslin: I am sorry but I ask the Acting Chairman that if statements are made that speak to the bona fides of the people here, we get an opportunity to answer the question that the Deputy put again to me, namely, that we had no interest in or did not put a priority on value for money.

Deputy Louise O'Reilly: That is how it seems to me.

Mr. Jim Breslin: I reject that plainly. We were using the resources of the State for the most valuable thing we could possibly do, which was to prevent people needing to access our healthcare services and not having hospitals available to them. I stand over the decisions that were made.

Deputy Louise O'Reilly: When it became apparent that a lot of money would be paid for capacity that would not be required, which is a testament to the work done by the general public and the fantastic work done by healthcare workers, and that that capacity, and cognisant, as I am sure Mr. Breslin is every day of the week, of the hundreds of thousands of people who are on waiting lists, was any plan B put in place? I am specifically referring to the period between the announcement and the signing of the deal. In that week, was any consideration given to the possibility that we might not use all of the capacity and making a plan B available to ensure it was utilised? This morning, representatives of doctors and consultants were very clear in their belief that there was no plan B and that the plan was only to secure the capacity but not necessarily to make full use of it? Was any thought given to a plan B in terms of us not using the

capacity?

Mr. Jim Breslin: Yes. The heads of terms have been laid before the Oireachtas and they outline the different usage to be made of the facilities. Even before the agreement was reached, part of that was a plan B, that if the facilities were not needed for Covid-19, they would be used for other purposes. That was the priority. In parallel with having them on stand-by for Covid, we would also use them for other purposes. The one-----

Deputy Louise O'Reilly: With respect, that is not a plan. That is-----

Mr. Jim Breslin: Could I finish, please?

Deputy Louise O'Reilly: -----a statement about how to use the capacity. A plan would detail what it was to be used for, and I did not see that in the heads.

Mr. Jim Breslin: I think there is a problem in that when I am finishing the reply I am hearing the Deputy and I am not able to respond.

Deputy Louise O'Reilly: I am conscious of the time.

Mr. Jim Breslin: It is written into the agreement. The HSE could speak to the operationalisation of that and the different cohorts that were identified, both essential care and more routine care, but within the context that NPHET had issued its advice on 27 March that routine treatment was to be paused.

Deputy Louise O'Reilly: I respect and I am aware of that. However, that advice did not remain in place for the duration of this and it is not in place now. What preparatory work was done to ensure that the best use could be made of that capacity for which the taxpayer is paying very dearly? I will say again, and this is my opinion, that the plan was only to get the capacity but not to make the maximum use of it. I would have thought, given the fact there are hundreds of thousands of people on waiting lists, as I am sure Mr. Breslin, Mr. Woods and others are conscious, that some thought would have been given to a plan with dates, procedures, etc. It strikes me that was not done and we will exit this and enter into the post-Covid healthcare world in the same, if not a worse, situation in terms of our waiting lists and with the capacity constrained by virtue of the fact that physical distancing will apply. It is going to make it even less likely those procedures will be done, and those lists will be even longer. It does strike me as a missed opportunity.

Mr. Liam Woods: In terms of her observations on waiting lists generally, the Deputy is correct. We have seen significant growth in the time of Covid-19.

With regard to the heads of terms, it has been referenced already that there was a provision, which has been exercised, to undertake work that is non-Covid related. There are detailed interactions with each of the private hospitals around that and the National Treatment Purchase Fund, NTPF, as I referenced earlier, has also played a role in identifying patients who are currently on waiting lists and can be treated. The challenge for us, as the Deputy has rightly identified, is to do as much as we can between now and the end of June and negotiate an arrangement going forward that allows us to provide appropriate care.

Acting Chairman (Deputy Jennifer Carroll MacNeill): Thank you, Mr. Woods and Mr. Breslin. Deputy Burke has five minutes.

Deputy Colm Burke: I thank each of the witnesses for their presentations and the work

they have done over what has been a very difficult four months.

The impression being given by some members is that today we could tell the private hospitals we want all their beds and tomorrow we could tell them that we are sorry, we do not need them. It is wrong that this kind of impression is being given out, and Mr. Breslin might clarify this, because my understanding is that the agreement was made for three months but plan B set out that if this epidemic lasted longer, the agreement could be extended further. Am I correct in saying that?

Mr. Jim Breslin: The HSE had the option to extend it by a further two months that it could exercise unilaterally, so that would have been five months. Thereafter it would have been extended voluntarily, so we have an agreement now that it is at the minimum. The Government decision is that we will end it after the three-month period.

Deputy Colm Burke: As part of the agreement, my understanding is that if Mr. Breslin wanted it to end after the three-month period, he would have to give a month's notice, which has now been given. Am I correct in saying that?

Mr. Jim Breslin: Yes, we gave the notice required which will see it finish at the end of June. That is what we could do under the contract.

Deputy Colm Burke: In other words, it is incorrect to give the impression, which some people seem to be trying to do, that this was just dreamed up overnight and there was actually quite a careful plan put in place.

Mr. Jim Breslin: There were a number of successive elements built into the plan. One was in respect of the termination provisions, which were in favour of the HSE. It could decide to extend or it could terminate, so having that available to the HSE unilaterally in this situation was a good thing to have and we have exercised it. The second element was the type of services to be provided, which was also at the discretion of the HSE. It was set out in the common purpose of the agreement but the HSE itself could make the referrals over to the private hospitals.

Deputy Colm Burke: I will move on to the issue of using the facilities for the next four weeks. We had an example in Cork where, more than 12 months ago, we had a particular problem on access to gynaecological services. We had more than 4,500 people on a waiting list, and a lot of these were day care procedures.

Have we identified any list at this stage with regard to particular areas where we can use the private hospital facilities over the next four weeks and get the maximum use of it? Is there a plan in place for the next four weeks for dealing with that?

Mr. Liam Woods: Yes, there is. We are looking to grow the occupancy as best we can to do that. As I said earlier, at the moment we are doing cancer work in hospitals and we have done cardiovascular work and gastroenterology work and transplant work has been undertaken in one hospital. There is a plan to do significant work. With specific reference to gynaecology list in County Cork, there is a strong focus on that. As the Deputy knows, much good work was done in the last 12 months on addressing that list, and there will be a focus on that in the next three to four week period.

Deputy Colm Burke: To go back to the other issue in relation to elective hospitals, we have identified clearly that there is a need to build three elective hospitals and that has been identified for some time. In Cork there is much land owned by the HSE. Sarsfieldscourt is a

site that could be immediately fast-tracked. Is there any plan at this stage to look again at fast-tracking that, now that we are going to have difficulties trying to keep the same capacity for dealing with procedures in our existing hospitals? We now need to urgently look at what we can do in a very short time period.

Mr. Liam Woods: Work is already under way, as I think the Deputy is aware, looking at potential sites in Cork. Sarsfieldscourt in Glanmire is one site owned by the HSE which could form part of that consideration, and there are others. There is a process under way with a view to----

Deputy Colm Burke: Have we timelines and, if so, can we bring forward those timelines?

Mr. Liam Woods: There are timelines. I do not have them with me, but there is a process under way already, specifically in Cork.

Deputy Colm Burke: In view of what has now occurred and given that the population of Cork has increased by more than 120,000 over the last number of years - it has gone from about 410,000 to 542,000 and it is growing - can we now bring forward those timelines? We had to take over two private hospitals, the Bon Secours and the Mater Private, in order to deal with this coronavirus.

Mr. Liam Woods: Yes, absolutely. I would emphasise, however, that before Covid-19 there was already a clear programme in Cork, and that should continue, and should conclude as quickly as possible.

Deputy Colm Burke: Can we get an idea of timelines?

Mr. Liam Woods: If I can return to the committee with that, I will do so.

Deputy Colm Burke: Okay.

Given the difficult times in respect of some of our nursing homes, do we have a difficulty moving people out of hospitals? How many beds are currently occupied by people who really should be in step-down facilities? How fast can we deal with that issue in order to create the capacity for procedures patients now require?

Mr. Liam Woods: On delayed transfers of care, at the moment the number is around 400 in the acute system. It has gone up from a low of just over 200, if we go back a few weeks. That is an issue we are working on. It is not all nursing home-related and some of that will be for home care or other specialist care, but that is a factor in the system at the moment. Work is under way with a view to ensuring we move patients to appropriate locations of care as quickly as possible.

Deputy Colm Burke: Can we get deadlines for bringing it back down to where it was?

Mr. Liam Woods: That is an ongoing piece of work because each week the system will produce a further 130 or so people who need to be discharged to a care environment or a home environment with support. There is a project under way with regard to managing delayed transfers of care, and in terms of the Deputy's information request-----

Acting Chairman (Deputy Jennifer Carroll MacNeill): We have gone way over but we had extra time. I see we have another speaker. I call Deputy McGuinness.

Deputy John McGuinness: I want to point out to Mr. Breslin that the last time he appeared

before the committee, a number of questions were asked, and a commitment was given that we would receive a reply in writing. To my understanding that has not happened to date. Some of the very same questions were asked again today. Will he give us a commitment that the questions from the last day at least will be answered?

Mr. Jim Breslin: The procedure is-----

Deputy John McGuinness: I know the procedure.

Mr. Jim Breslin: The procedure is that the secretariat writes to me as Secretary General, and I think I got the letter on a Thursday with ten days to respond, which would have been the following Friday.

Deputy John McGuinness: It would have saved a lot of time today, had those questions been answered. Earlier on, Mr. Breslin asked a question about-----

Mr. Jim Breslin: I was going to reply to the Deputy's-----

Deputy John McGuinness: ---- the State Claims Agency, and the fact that the letter had informed those concerned that if the consultant had not signed the type A contract, the tests would not be processed. Mr. Breslin says that was fixed up in 48 hours but it does bring about a situation where there is a growing mistrust between the consultants and the Department. That was reflected again in the context of the contract itself. Some consultants wrote to us and told us that the type B contract would have cost far less than the type A contract and done the same job. I cannot ignore these comments from consultants but I am not pointing a finger at Mr. Breslin or the HSE. I am simply saying there is a staggering contradiction in terms of the witnesses as they present to us and how they understand what has happened.

The consultants' representatives this morning informed the committee that they had written to the HSE and the Department of Health regarding the contract and how matters were progressing and they had received no written reply. They told us that there were 600 consulting rooms in place and the officials ignored all of this. I am not saying they are right and Mr. Breslin is wrong. I am simply saying that is what was said.

To Mr. Woods I point out that a witness this morning highlighted the serious difficulties relating to telemedicine and dealing with those affected by mental health issues. In a separate letter from a consultant, they talk about the serious mental health issues and the well-being of patients now emerging from Covid-19 and the need for a direct one-to-one consultation. They are telling us that telemedicine will not work.

Another witness this morning told us that the system of technology being used is abysmal. He said that if we went back to - I do not know whether he said the 1800s - that we would probably have the same thing in place, recording matters by manually entering the information. That contradicts what Mr. Woods said earlier. There are a number of other contradictions. Why has such a difference emerged? If the parties were close together, moving towards taking charge of the private hospitals and if they understood what was going on, there would have been a greater and more significant cross-use in terms of public and private healthcare.

Finally, we were told this morning that 1 million patients have been affected by the cancellation of appointments and procedures.

Mr. Jim Breslin: I think all of us had extensive engagement with the IHCA throughout this

period. I remember walking up and down my kitchen on a Sunday morning talking extensively to the general secretary of the IHCA. Throughout weekends and late at night a range of different officials were dealing with the association. We had protracted engagement. We were giving clarifications to them. That does not mean that we were agreeing with the IHCA but there was no lack of engagement from us trying to get to solutions. It is important to recognise that we were working within the policy parameters set by Government. One of those parameters was that there would be no private practice; it would be public only. There would be no private fee arrangements over this period. When the IHCA were looking for a type-B contract, they would have understood, though it may not be commonly known, that such a contract would have entitled them to private fees for treating patients. That was contrary to the mandate we had been given and to the heads of terms that had been concluded with the Private Hospitals Association.

Deputy John McGuinness: Would Mr. Woods like to comment on the issue of mental health? That is a concern.

Mr. Liam Woods: In terms of use of telemedicine, first, we had more than 80,000 consultations using telemedicine in April. I acknowledge that is a significant mechanism to provide services to people who would not otherwise have received such service. I also acknowledge that it would be broadly acknowledged that a first consultation typically would not take place using telemedicine, in other words electronically, but it would be quite routine in other jurisdictions that further consultations can and do. There are excellent systems for that. The HSE has those systems and they are in use.

The Deputy made a point about 1 million patients affected------

Deputy John McGuinness: Would Mr. Woods not accept what the consultants said to us this morning, namely, that is simply not the case and the technology now in place is abysmal? I am citing the consultant.

Mr. Liam Woods: There is a diversion of views. Because we are close together does not mean that we agree. We were very close together for quite a while. In fairness, the reference to technology to which the Deputy referred is about recording patients as they attend. A system has gone in, through the NTPF, to private hospitals to support that, as the private hospitals themselves have a variety of systems and we have to depend on what is there given the short timescales.

Another point I should touch on is that the suggestion that 1 million patients are impacted seems excessive. There is an impact in outpatients in the public system, where 3,200 consultants are working. We can see there is a loss of appointments of about 150,000 in April. From our perspective, that is significant and we must catch up on that. I accept the Deputy was reflecting what was represented to him but it sounds to me, bar seeing more detailed information, that the figure is excessive.

Deputy Michael McNamara: Cancer screening was stopped across the country and is still suspended. Some private doctors who did not sign the type A contract continued to carry out screenings in their rooms. They were told on a Friday afternoon that they would no longer be indemnified by the State Claims Agency in respect of those. In effect, they were prevented from carrying out any colposcopies or other screenings. Who made that decision?

Mr. Jim Breslin: I dealt with that earlier. I was not involved in the individual incidents but within 24 hours, a clarification was issued. The State Claims Agency was seeking to clarify the

extent to which clinical indemnity was covering the various activities under this undertaking and sought to put clarity in respect of that. It dealt with that issue but very quickly, the agency rescinded that and clarified that it would be covered.

Deputy Michael McNamara: It was a just lack of clarity rather than a decision.

Mr. Jim Breslin: It was an unfortunate issue but it was rectified.

Deputy John McGuinness: I compliment the Acting Chairman's on this session. It was very efficiently run.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Deputy McGuinness.

Deputy Michael McNamara: Much better than usual.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I wish to take the opportunity to thank everyone and to thank the witnesses, not just for their attendance today and the preparation for it, but for all the work they have done over this period. The exceptional work and commitment to public service epitomises public service values, has been extraordinary and they have worked extraordinarily hard. If I never got to say anything else on this, I would just want to say this to the witnesses and to thank them. Mr. Breslin and I worked together a very long time ago and I know very well that often, the level of work that goes on behind the scenes in Departments is not always reflected in public.

I wish to ask about the sequence. It is worth remembering, as it seems that we have moved on collectively very quickly from the terrible situation which we faced at the outset. There was a global pandemic with numbers rising, ICU admissions were rising and there was evidence from other countries of ICU capacity being overwhelmed. That would have resulted in exceptionally difficult decisions. It was on that basis that the decision was made to take over the private hospitals.

Mr. Jim Breslin: Yes. Earlier, I gave figures of a doubling of ICU capacity. Given that we are not well endowed with ICU capacity, had that continued at that rate, we would have exhausted our ICU capacity within a week to ten days.

Acting Chairman (Deputy Jennifer Carroll MacNeill): Mr. Breslin said that a decision was made very quickly in respect to private hospitals; in a matter of days. Can he give us a sense of how quickly? What sort of period did he have to make that decision?

Mr. Jim Breslin: At Government, the date that was used earlier was 24 March, and by 30 March, the agreement was in place and patients were being admitted under the agreement into private hospitals.

Acting Chairman (Deputy Jennifer Carroll MacNeill): At the same time, NPHET had suspended - if that is the correct term - general access to the hospitals in order to try to reduce community transmission and infection within hospitals.

Mr. Jim Breslin: We were dealing with the same issue, which is that we were looking at a surge, but we were using different remedies. One was to try to flatten the curve and stop the surge, but we knew that even if we were successful, there was a lag in the incubation period. Meanwhile, we were trying to put the capacity in place for the surge. The fact that the first strategy worked meant we did not need as much in the second, but they were both valuable strategies.

Acting Chairman (Deputy Jennifer Carroll MacNeill): As a representative, the queries I was getting in the first instance related to whether people could get access to treatment, and that got resolved pretty quickly. People were getting access, for example, to injections to the eye - I do not want to get the term wrong - or continuing cancer treatment. Now the questions are about getting access to ongoing diagnostic tests. I am sure Mr. Breslin is aware of that pressure as well. What people are really looking for is that sense of a plan over the coming months. I know Mr. Breslin will be working on it.

We were talking about consultations and the opportunity to do virtual consultations. I was talking about it to Children's Health Ireland earlier. It was talking about parents doing videos, sending those in as consultations and doing a certain amount of diagnostic work, and only then would they have to attend for bloods or other things. There is a great opportunity for innovation at this time as well.

I thank the witnesses for attending and for their work. We will suspend until 4.30 p.m. when we will meet the Department of Foreign Affairs and Trade, the Department of Health, and the National Transport Authority on the issue of travel restrictions.

Sitting suspended at 4 p.m. and resumed at 4.30 p.m.

Deputy Michael McNamara resumed the Chair.

Travel Restrictions

Chairman: Before introducing the officials I wish to advise that the Business Committee has yet to determine whether we can meet on Thursday morning. Invitations have been extended, but at a very late hour, to the World Health Organization, WHO, and the European Centre for Disease Prevention and Control, ECDC. There is also the issue of whether it is technologically possible to conduct a meeting by video link. I hope it would be but we are in the hands of the Houses of the Oireachtas Service in that regard. I am sorry to inconvenience members but we hope to still have a meeting on Thursday morning and we will know by lunchtime tomorrow.

Deputy John McGuinness: Bureaucracy at its best.

Chairman: Those are the Deputy's words, not mine. We are joined this afternoon by officials from the Departments of Foreign Affairs and Health and the National Transport Authority, NTA, to deal with travel restrictions. I welcome Mr. Niall Burgess, Secretary General, and Dr. Ann Derwin, director general, global Irish services, Department of Foreign Affairs. I thank them for joining us.

Mr. Jim Breslin, Secretary General, Department of Health will be in committee room 1. He joined us for the previous session and I thank him for joining us for a second session today. He is accompanied by Mr. Colm Ó Conaill, principal officer, Department of Health. I also welcome Ms Anne Graham, CEO, and Mr. Tim Gaston, director of public transport services, NTA.

I wish to advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to this committee. If they are directed by the committee to cease giving evidence in relation to a particular matter and continue to do so, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these pro-

ceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable.

While we expect witnesses to answer questions asked by the committee clearly and with candour, they can and should also expect to be treated fairly and with respect and consideration at all times in accordance with the witness protocol. I ask any witnesses who wish to raise any issues in that regard to do so. I ask all the witnesses to confine their opening remarks to five minutes because we are very constrained on time. Can we have Mr. Breslin's opening remarks, please?

Mr. Jim Breslin: I thank the committee for the invitation to address the committee again on the issue of travel restrictions.

The World Health Organization offered guidance in a strategy document in April for countries which were considering lifting restrictions detailing the additional measures that would be needed to ensure that the spread of Covid-19 could be contained. Among these, the document recommended that the risk posed by imported cases of the virus should be managed. As the committee will be aware, it was imported cases that led to transmission of the virus in Ireland in the first place. The European Centre for Disease Prevention and Control, ECDC, published a paper on considerations for travel-related measures to reduce the spread of Covid-19 on 22 May last. That paper notes that while community transmission is high, imported cases are likely to make less of a contribution to the overall spread of the virus and, therefore, restrictions are not needed. However, when community transmission reduces, as is the case in Ireland currently, imported cases could be the cause of a second wave of infection and governments should consider the need for restrictions or other measures accordingly. The Government has already taken several measures to curtail non-essential travel. On 25 March, the Taoiseach announced that no non-essential travel should take place in the State or overseas.

Thankfully, our progress as a country in managing the disease has allowed us to make progress in implementing the Government's roadmap for the reopening of society and business. Phase 1 of the roadmap sees the permitted range of travel raised from 2 km to 5 km and phase 2 will see that raised further. There have been questions about the step nature of these changes but the rationale is to allow public health officials to monitor the spread of the virus when the restrictions are modified.

When the full restrictions were in place, the number of potential contacts of each infected person plummeted as there was less circulation of people. As the restrictions are relaxed, we can expect the number of contacts to increase again but, hopefully, in a way that continues to see the spread of infection controlled. Everyone is anxious to have the benefit of allowing some return to the normal functioning of society, which has its own public health benefits, as long as this is done carefully.

As for travel from overseas, the roadmap sets out a clear expectation that all passengers arriving in the State are expected to self-isolate for 14 days. Following advice from the WHO and the ECDC, the Government introduced a form on 26 April for passengers coming into the State to fill out, which gives information on where they will be staying. A system of follow-up calls was also put in place with calls made at the two-day and 12-day mark. As the committee will be aware, it is believed that Covid-19 has a 14-day incubation period. At first, this form was voluntary. However, as of Thursday last, 28 May, this form has become mandatory and incoming passengers are also required to update the information on the form if it changes and to answer

any queries made at their point of entry or as part of follow-on calls. These requirements were introduced to increase compliance in completing the form and to enable contact tracing if any passengers arriving from overseas contract or are suspected to have contracted the virus.

The Covid-19 passenger locator form collects information from arrivals from overseas, including their name, date of birth, and the details of their flight or ferry. Those passengers who are not staying in the State, for example, travelling to Northern Ireland or overseas, do not have to provide the address information. Those passengers remaining in Ireland are required to provide details of an address where they will be staying for the 14 days following their arrival.

The form provides information on why these details are being collected and how it will be processed. The form will be kept for 28 days and then destroyed unless it is needed for enforcement of the regulations. The reason for the 28-day retention period is to enable contract tracing.

The regulations that introduced the form also introduced several offences which are punishable by a fine of €2,500, six months imprisonment or both.

Passenger numbers are at approximately 1% of their usual volumes at present but that may change. Other countries in the EU, many of which had bans on non-essential travel, are reopening and allowing their citizens to travel. Airlines are restoring their flight itineraries and are encouraging people to book trips.

The right time to put special conditions on people who are proposing to travel is now. We need to maintain awareness that the danger has not passed and that people are taking a risk of spreading the virus by engaging in non-essential travel.

The advice of NPHET to the Minister for Health on 3 April was that both the passenger locator form and the self-isolation for 14 days should become mandatory and the Government has asked the Minister for Health to examine the issue of a 14-day self-isolation period for people arriving in the State. This is being considered by several Departments and will be subject to further consideration. There are complex issues of international and domestic law involved. The EU position and that of other member states is also evolving.

The WHO has said that the most plausible future scenario in the dynamic of Covid-19 may involve recurring epidemic waves interspersed with periods of low-level transmission. That is the context within which travel restrictions apply and continue to be reviewed. It is important that, where travel needs to take place, it does not pose significant risk to the wider public.

Mr. Niall Burgess: I welcome this opportunity to meet the committee today and to outline the contribution of the Department of Foreign Affairs and Trade to the Covid-19 response. This response has extended from consular support to assistance in the wider procurement efforts, the secondment of a significant number of staff to other essential services, the mitigation of some of the global impacts of the pandemic, the maintenance of a global mission network and, of course, the maintenance of other ongoing essential work.

With the permission of the Chairman, I would like first to address the actual and likely impact of travel restrictions on those wishing to enter the State. As this Department's particular responsibility rests with the protection and care of Irish citizens overseas, I will focus my comments on the challenges faced by citizens seeking to return to the State.

Our consular directorate, in close co-operation with our network of embassies and consulates overseas, has been assisting citizens affected by Covid-19 pandemic since the virus first

emerged in China in January. By mid-February, the pandemic was spreading rapidly around the world and, as a result, countries were imposing internal and international restrictions on travel, shutting down public spaces, suspending flights and closing airspace, with an increasing number of our citizens facing the prospect of being stranded abroad. In response, we activated a dedicated helpline to provide direct support and advice. Drawing on staff redeployed from across the Department and from the Passport Office, the crisis centre scaled up quickly to operate on a 24-7 basis, receiving up to 2,000 calls per day. By the end of May, the centre had handled more than 20,000 contacts from Irish citizens at home and abroad.

The first repatriations we assisted with were from Wuhan, China, in late January, followed by assistance to citizens stranded on cruise ships in Japan and Cambodia. To date, we have advised and assisted well over 6,000 citizens in returning home from 129 countries. This has included providing information about available routes and connections, ensuring seats on commercial flights wherever possible and negotiating places on flights chartered by the UK, EU and other like-minded partners. In a few exceptional cases – where there were significant groups of Irish citizens with no alternative options to leave and in circumstances that made them particularly vulnerable - we chartered planes ourselves, bringing back citizens from Peru, India and Nigeria.

In all operations, we have prioritised public health considerations, liaising closely with the Department of Health, the Department of Transport, Tourism and Sport, the HSE and the Dublin Airport Authority.

Our consular directorate has also been working closely with our embassies and consulates on complicated and often very distressing issues such as hospitalisations and deaths overseas, repatriation of remains, and the treatment of prisoners in the context of Covid-19.

Although great progress has been achieved in responding to the many consular challenges posed by Covid-19, this operation is far from over. At present, we are aware of more than 1,000 citizens dispersed across many countries, some in remote locations, with an interest in returning home and we are working with them to provide advice and help them with access to essential local services. The potential future challenges which our citizens' will face will depend to a large extent on the evolution of the pandemic over the coming months. In the meantime, we have established a dedicated Covid-19 response fund for Irish communities abroad designed to protect the elderly, to provide mental health supports and to meet the needs of those made newly vulnerable by the pandemic.

As regards outward travel, since mid-March the Government has advised against all non-essential travel overseas and the security status assigned to all countries was upgraded to reflect this advice. We continue to advise against all non-essential travel.

As I am sharing time with colleagues from the Department of Health today, I should mention the close working relationship we have in addressing this crisis. In that context, for example, we have seconded several staff from the Passport Office to the HSE to assist with contact tracing. In our response to Covid-19, we are keenly aware that we must consider the shared geography of the island of Ireland and the cross-border mobility of people through close and ongoing contact, both North-South and east-west. The Government is, therefore, engaged in co-operation with the Northern Ireland Executive and the British Government with the intention of delivering an effective response to the threat of Covid-19 on behalf of all the people of this island. The Irish Government's roadmap to ease the Covid-19 restrictions, published on 1 May, acknowledges the need to continue to work intensively on our approach to travel restric-

tions and controls at ports and airports and on the need for co-operation with Northern Ireland, the UK and our EU partners.

Throughout this crisis, we have also been clear on the need to ensure that our global network of embassies and consulates remains operational to deliver essential services. All 90 Irish missions across our network have continued to work, notwithstanding significant challenges. This has facilitated essential business, including ongoing EU business and the management of Brexit. It has also facilitated extensive reporting on the progress and impact of the disease globally and the measures taken by other governments to address the pandemic and the challenges of economic recovery as an input to policymaking at home. It has supported our efforts to source and ship critical medical supplies for the Covid-19 response. Our embassies in Beijing, Seoul, Tokyo and Berlin and a small team in the Department here in Dublin have been working closely with IDA Ireland, the HSE-----

Chairman: I ask Mr. Burgess to conclude.

Mr. Niall Burgess: I will conclude there. My full statement has been provided.

Chairman: I thank Mr. Burgess. His statement has been circulated.

Ms Anne Graham: I thank the Chairman for the invitation to attend the committee.

Prior to the crisis, the National Transport Authority, NTA, had been recording a significant growth in public transport usage in our cities and towns and in rural Ireland thanks to increased investment by the NTA in new and enhanced services. However, the Covid-19 crisis and the Government's response, including school closures from 13 March followed by the requirement to stay at home which applied from 23 March, had a profound and ongoing impact on the demand for public transport. Daily demand is now typically between 10% and 20% of what it was prior to mid-March. Weekly demand in early March was approximately 5.6 million passengers. By mid-April this figure had declined to 500,000 passengers, which is less than 9% of normal demand levels. Although demand remains very low, some recovery in passenger numbers has been apparent in recent weeks.

Throughout this crisis, the NTA and the public transport operators have closely followed the public health advices. In line with those advices, we have implemented a number of measures across the public transport system for enhanced cleaning regimes and to facilitate appropriate social distancing. The NTA worked with public service obligation, PSO, public transport operators to provide consistent signage on board all bus, rail and Luas services to encourage physical distancing by passengers and to reduce the risk of close passenger contact with drivers. These measures were rolled out in early April. The impact of these measures has been to reduce dramatically the passenger-carrying capacity of each vehicle to around 20% of its former level in the case of buses, with a larger reduction in the case of rail. The reduced demand for travel, however, was such that this social distancing was easily achieved on all services.

Prior to Covid-19, each public transport vehicle was cleaned internally and externally each night before entering service the next morning. From early March onwards, this cleaning regime was progressively enhanced by more intensive night-time cleaning measures, focusing in particular on passenger touch points such as grab rails and seat handles. These cleaning measures were later supplemented by on-board cleaning of passenger touch points during the service day.

On revised timetables, we put in place Saturday plus timetables on bus and rail services.

This reflected the huge decrease in travel demand that had taken place but we maintained sufficient services to meet residual demand by essential travellers at all times, especially in the early morning when many healthcare staff required public transport services. Luas and regular rural services continue to maintain normal schedules. The demand responsive services provided by LocalLink supported local communities in delivering supplies, particularly to those who were cocooning. Throughout the crisis, the dedication of operator staff and drivers in particular in continuing to provide public transport services to those who still need to travel has been remarkable, and I would like to record that here today.

The NTA is aware that the commercial bus and small public service vehicle sector, like all businesses, has been severely impacted during this crisis. The Government has put in place a number of supports for businesses and the NTA is continuing to work with these sectors and other stakeholders to do all within our powers to support them.

In planning for reopening phases, the pattern of travel on public transport has changed radically and is likely not to immediately return to the same patterns that were in place prior to the Covid-19 pandemic. The planning of the public transport response to the Government's roadmap is challenging as there are now new norms. The authority has made extensive contacts with employer, industry and retail bodies as well as larger third level institutions to ascertain the manner in which various sectors expect to phase their reopening in line with the Government roadmap. At a high level, the response to the various reopening phases is as follows. In phase 1, commencing 18 May, we have maintained the reduced weekday timetable. We lengthened trains where required and provided additional services at peak times as required. We will introduce normal Monday to Friday timetables for commuters on bus and DART for phase 2. During phases 3 to 5 we will continue to monitor travel demand and work with operators on providing additional services where needed, subject to availability of fleet, drivers and funding. The resultant travel demand in response to phase 1 of the easing of restrictions has been higher than expected. We believe that there is a large percentage of non-essential travel being made on public transport, which is using up the capacity that we had planned for phase 2. Public transport capacity with social distancing will be significantly challenged without a number of other supporting measures. These include encouraging organisations to continue to facilitate working from home, remote learning, online shopping and online appointments where possible; discouraging use of public transport at peak times except for essential travel; and encouraging staggered start times and longer opening hours to spread demand out of peak.

The NTA is working with local authorities to introduce mobility plans in cities, starting with Dublin city centre, to manage travel demand to urban centres, to protect space for public transport and provide additional space to meet increased cycling and walking demand. We will fund the emergency infrastructure identified by local authorities; encourage people to keep their journeys short and local wherever possible; and promote cycling and walking instead of public transport or car wherever possible. There is no doubt that there needs to be a radical shift in the use of active travel modes over the next few months in our towns and cities.

Chairman: I must ask Ms Graham to conclude.

Ms Anne Graham: Thank you.

Deputy Norma Foley: I welcome the witnesses. I compliment the Department of Foreign Affairs and Trade. Many of my constituents in County Kerry were among the 6,000 who were anxiously seeking to be repatriated in very difficult times. They were stretched across 129 countries throughout the globe. I am very grateful for the proactive assistance that was received

from the Department through the helpline, the mercy flights and also in providing connectivity with other flights where necessary.

I want to address a question to Mr. Breslin. Kerry is a very strong tourism county. We are deeply reliant on tourism and last year generated in excess of €500 million from that sector alone. We want to open up but we absolutely want to do so safely, securely and with best practice from a health point of view. I note from Mr. Breslin's report that mandatory self-isolation is being mooted. Is the Department currently looking at the notion of rapid testing at airports, with a very quick turnaround? That would make a great difference to counties like Kerry and other tourism areas. It would breed confidence if the turnaround was very quick. Is that being considered from a health best practice point of view?

Mr. Jim Breslin: I thank the Deputy. The best means we have for generating activity within the country is to keep the virus low. That would allow us all to circulate, including to go to beautiful parts of the country on the west coast. I hope that will be something we will be able to do as the phases continue.

On overseas travel into the country, there are difficulties with a testing regime. The tests only identify the virus at particular points in the cycle. One could have undetected Covid-19 for somebody in the early days after having contacted another individual with Covid-19. It just would not be in their respiratory tract. The test result would be "Not detected" but they would hear that as, "I do not have Covid." There is quite a period where people are asymptomatic. When they subsequently developed symptoms, they might dismiss them because they had been tested. Countries have looked at it but there are issues around it in the message it sends out. The most important thing is that people are aware of their own symptoms and respond quickly to them. It is also important that we would not have people coming from areas where community transmission is higher than it is in our own country. That is hard to achieve because the knowledge we have of different countries is predicated on them having a testing regime that is similar to our own, and not every country has that. The EU has talked about corridors and different relationships between countries. That, again, would all be in subsequent phases. I do not think anything we are talking about will be immediate but they are potentially matters being worked out at European level for further phases in the reopening process.

Deputy Norma Foley: I thank Mr. Breslin. I turn to Ms Graham from the NTA. She stated that in phase 1 the expected take-up of those needing public transport far exceeded what the NTA had anticipated. How are we placed for phases 2 and 3? Are we facing a scenario where some people will have to stay at home because they do not have access to public transport to get to work? How is the 2 m rule impacting on the NTA's availability of access to public transport? What is Ms Graham's view on the 1 m to 2 m distinction?

Ms Anne Graham: As I outlined in my statement, the impact of the 2 m social distancing has reduced the capacity on our buses by about 20% and on rail by a lower figure. It significantly impacts on the numbers that can travel on public transport. It means we recommend that as many people as possible continue to stay at home and not travel during the different phases of reopening in the Government's roadmap because there are restrictions on public transport capacity due to social distancing. Moving to 1 m would double the available capacity but it is really a matter for the Government, the public health experts and the Department of Health to make recommendations in that regard, and we will follow the guidance associated with that.

Deputy Colm Brophy: I join my colleague in acknowledging the work on repatriation done by the Department of Foreign Affairs and Trade. A number of constituents have contacted

me about it, particularly in respect of the operation in Peru, and it is an absolute credit to the people on the ground, the organisation and the people in Dublin who helped to facilitate it. The Tánaiste also worked hard on it. It was vital not only for those people who were overseas but also for their families who went through incredible stress. It is worth acknowledging that because we move on so quickly in terms of where we are with this pandemic.

I wish to follow up on a theme raised by Deputy Foley, namely, the 14-day quarantine to be required by people coming into the country. I address this to the HSE and, in the absence of representatives of the Department of Transport, Tourism and Sport, I would like to get the perspective of the Department of Foreign Affairs and Trade as well. We are effectively putting ourselves in a situation where, if that remains in place for the next few months, there will be no inbound tourism in Ireland this season. That will have a huge impact, not just in Kerry but in Dublin and on the whole economy of the corporate hospitality area. It is strange for people to see other countries that were far worse affected than our country, such as Spain and Italy, being reopened to allow inbound travel, particularly from Europeans. We seem to be coming to our decision late, and doing it at a time that seems the worst in almost every way.

If the quick test cannot work, why can we not, as in the case of Greece recently, draw up a list of countries where the R-nought number or the level of Covid presence is roughly equivalent to ours and work out a way of processing inward-bound travel? We may have to have restrictions from certain countries but we cannot tell the entire hospitality industry that there will be no inbound tourism. We have the worst of both worlds in one respect. One has a mandatory form and an optional quarantine. That will play out, however, on international social media and international coverage as there being no point going to Ireland as one cannot go as it is closed. I would like to hear how we are going to move, as well as how quickly we can move, on that, particularly for fellow EU member states.

Mr. Jim Breslin: Obviously this is fluid. As I said, the Minister for Health has been asked to look at the issue of mandatory self-isolation and come back to the Government on it. I will not prejudice what that process will involve. It will, however, involve significant input across relevant Departments, including the Departments of Health, Transport, Tourism and Sport, Justice and Equality, Foreign Affairs and Trade, the Taoiseach and others, to look at this issue and come back.

It is relevant because, if we go back to the start, if one gets to a point where community transmission is really low in the country, then we can all circulate again. That is exactly what we want to do. We want to get the economy, industry and retail back. If during that process, however, one imports cases from travel from overseas, then one can restart the uptick in cases again. One can then have a break-out of cases leading to a wave. There is a trade-off and it is about the level of risk involved.

Deputy Colm Brophy: I just want to come back in because I have 52 seconds left.

The problem I have with that thinking is very simple. If one continues that on to the basis of what Mr. Breslin is saying, then there is no international travel until a vaccine. If that is the case, and that is our thinking, then we need to spell that out because of the implications for our tourism and the hospitality sector. I cannot remember the exact figures but it was approximately 10 million visits last year versus a population of half that effectively on the island. If everybody holidays at home, we simply do not have enough people here to sustain our tourism and hospitality industries. When can they see some light? At the moment, we seem to be turning the light off on them completely, while other countries, again with much worse Covid rates,

have made the decision that it is safe for them to re-open.

Mr. Jim Breslin: The Deputy referred to it in his question. It is not in this phase but there is a point down the road where one has sufficient knowledge of community transmission in other countries and good information on that. At EU level, it is being talked of as corridors. One might be able to have reciprocal arrangements with a group of countries. There might be other countries where they do not have the virus under control and from where one would not want to travel. That is the type of scenario at subsequent phases that one would potentially be able to look to generate.

Chairman: Thank you, Deputy Brophy. I call Deputy O'Rourke. Are you speaking for ten or five minutes?

Deputy Darren O'Rourke: It is for ten minutes. I thank the witnesses.

Has there been any assessment of the impact of the decision not to restrict travel at an earlier stage? There are indications in Britain of the impact of the Cheltenham festival and the Liverpool-Atlético Madrid game. Have we an assessment of these? It strikes me we acted late. We did not lock down or restrict movement early. We imported the virus. Was there an assessment of the impact of, for example, not introducing the passenger locator form as a mandatory measure earlier or having contact tracing added at an earlier stage? I am thinking in terms of Cheltenham but also in terms of the Ireland-Italy rugby game, as well as people returning home from skiing in northern Italy.

Mr. Jim Breslin: There are definitely phases to this. If the Deputy remembers the mid-term and people arriving home from Italy, that was in a situation where the knowledge of the virus as having been in Italy was current at that stage. Whether we could have foreseen that or not, all this is about judgment calls at a point in time. However, we did not have the subsequent information that subsequently developed.

I remember the recommendation that the Ireland-Italy match should be postponed and not go ahead. There was criticism from all sides about that. It was not just people saying we should have made the decision earlier. Many people said we should not have made the decision at all and should have allowed the match to go ahead. Regarding Cheltenham, the Deputy should be aware of the extent of the cases in the UK at the time. That is not to say that if we had to make the decision over again, we would make it but at the time of Cheltenham there were 590 cases across the whole UK. When we recommended that the rugby match with Italy be postponed, there were 15,000 cases initially, mostly in northern Italy, where a lot of the rugby supporters came from. Also at the time, we recommended that the St Patrick's Day parade be cancelled. Again, we were taking decisions as we were going along.

Deputy Darren O'Rourke: I am sorry to interrupt but we do not have an assessment of the impact of our response in terms of travel into and out of the country. It strikes me that other countries have assessed the impact of events in question in terms of the clusters they created. We are trying to assess here our policy response and interventions. It strikes me that it was later when we introduced the mandatory form rather than earlier.

Mr. Jim Breslin: I will come back to the mandatory form as I am still referring to the early phase. At that time, the recommendation of the European Centre for Disease Prevention and Control was that we not impose border restrictions because they are ineffective. Italy imported cases from China thinking it was fine because it had banned flights from China, but people had

made it to Italy anyway through indirect routes and there was take-off as a result of that. We were operating in that situation but the Deputy is correct to state the first of our cases came from northern Italy. To that extent, it had an effect on us. Whether we had the ability to insulate ourselves from that was questionable given that the individuals concerned were Irish people returning from holidays. We certainly were recommending self-isolation.

Deputy Darren O'Rourke: I will move on. I thank Mr. Breslin for the response on-----

Mr. Jim Breslin: Let me just answer the question on the passenger locator form. It is important to understand that the rate of travel into the country is down to 1%. Therefore, this is the right time to implement the form. It is not that we have our usual rate of travel. We have implemented the form ahead of time. Should we need it, we will have the information from the forms to contact trace.

Deputy Darren O'Rourke: On a related point, on which I am picking up, many have been hearing conflicting messages over the past week or maybe a little longer, be it from public health professionals or representatives of airlines and the airline industry. There is lot of confusion in this regard. People are looking towards the summer holidays and wondering what the landscape will be like. Some have their summer holidays abroad booked. I know people who book almost a year in advance. Some are anxious to get away on their summer holidays. People will be able to travel to Bergamo or Madrid in a couple of weeks if they want. Those areas were very badly affected by Covid-19. What advice is coming from the Department on what the landscape will be like? Can people expect mandatory self-isolation in June, July, August and September in Ireland? What are travellers to expect? What are employers to expect of their employees? What is the position of the Department on that?

Mr. Jim Breslin: The current Government advice is that there be no non-essential travel overseas. That will be kept under review and it may change. I will not make the decision on that. We input advice that informs the decision-making but I will not make the decision; it will be a Government-wide decision. Just as I will not make the decision, it will not be made purely on public health grounds. It is important, however, that people hear that the advice of the Government is that they do not undertake non-essential travel at the moment. That would include booking or entering into financial arrangements for non-essential travel. Most people are responsible and they think not only about themselves but also about their loved ones, families and so on. There is a risk attaching to travel so if people can avoid it, they should. There will be circumstances where people need to undertake trips. They weigh those things up but, at the moment, the advice is that if the travel is non-essential, it should not be undertaken.

Deputy Darren O'Rourke: It is the case, then, that it will be consistently under review? For those people who booked a family or summer holiday for July or August already, as far as a year back or earlier this year, what protections will there be if their airline is flying at that stage? Will the State give clear advice from the Department of Foreign Affairs and Trade and the Department of Health about what areas are safe for non-essential travel and what areas are not safe to travel to?

Mr. Niall Burgess: Our travel advice at the moment is to avoid all non-essential travel. That is based on the public health advice here.

Deputy Darren O'Rourke: Additional protections are afforded to consumers and travellers if the Department of Foreign Affairs and Trade says not to travel to certain countries.

Mr. Niall Burgess: That is true. As the health situation evolves in other countries and as our own public health advice evolves, our travel advice will evolve too. I do not want to go into speculation about where that may take us but from the start of this year, we have worked very closely with the Department of Health and the Chief Medical Officer to give advice which reflects both public health considerations here and the risks which one enters into by travelling overseas. That is not simply the risk from being in another country but the risk from undertaking travel too.

Deputy Darren O'Rourke: I have a question for Ms Graham from the NTA about the mandatory wearing of face masks on public transport. It strikes me, travelling through Dublin today, that very few people are wearing face coverings. I do not know if other people have the same experience. We have advice about wearing face masks but it is not mandatory. We nearly have as much information about the exceptions as there is about the wearing of masks themselves. I know that union representatives are looking for mandatory face masks. Will this be considered and introduced immediately?

Ms Anne Graham: It is not for the NTA to put forward advice about that. It is a matter of Government guidelines. NPHET advice is that the use of face coverings on busy public transport is advised. We certainly support that. We encourage our customers to use face coverings on busy public transport, especially as it gets busier in phase two. We are running a campaign on public transport and social media to ask all public transport customers to wear face coverings to protect drivers and operator staff as well as other customers. Making them compulsory or mandatory is a matter for the Government.

Deputy Joe O'Brien: Due to time limitations, I do not have many questions for the NTA but I want to make a point that has been touched on already. I got public transport here today and I was the only person wearing a face mask. That is especially worrying in the context of the fact that we are moving to phase two on Monday and many more people will look for public transport, and Ms Graham said the number of people using public transport at the beginning of phase one was more than the NTA anticipated. That was two and a half weeks ago, which was a very different place. We are a lot more lax with restrictions now. Monday could see a very difficult situation for public transport providers around the country because face masks are not being worn, by and large. When I got off the train, maybe one in thirty people coming off the carriages and onto the platform was wearing a face mask. There needs to be a much clearer message about what people need to do on public transport. Problems are brewing for Monday.

I would like to ask many questions but time is limited. How many local authorities have actively engaged with the NTA about reallocating space and the emergency funding that is available?

Ms Anne Graham: We just put out a call only a number of days ago so it will take a while for those local authorities to get in touch with us. We have approximately six or seven local authorities that have made contact with us to date but we expect to receive more submissions for funding to improve walking and cycling facilities.

Deputy Joe O'Brien: What kind of fund is available? What is the total pot, so to speak?

Ms Anne Graham: We have not put a figure on that. It is just that we are in a position to fund and we want to get as many proposals as possible in so we can move as quickly as we can to ensure we can put in place more walking and cycling infrastructure.

Deputy Joe O'Brien: I have three general questions for the Department of Health, and I will deal with the more specific one first. In comparing phases 3 and 4, I would like a medical or scientific opinion on whether we could see a position whereby if we see progression, it would be possible to move to phase 4 a bit earlier. I am just thinking of travel within the country and to the west coast, for example. Is it possible we will see a position where if there is continued dramatic improvement, the stages could be bumped up, so to speak?

Mr. Jim Breslin: An important caveat is that I am not giving a public health assessment because I am not a public health doctor. Within the Department of Health and the Government, everybody is on the record as saying the roadmap is just that. It is a living document and based on our travel and how we get along we can adapt our decision-making at various stages. It is important the three-week windows are built in to review each stage but it means, in light of our experience and that of other countries, we can act where we see new evidence around risk. For example, if something is in stage 4 because it is seen to be a high risk but evidence indicates it is a lower risk, it can be reviewed and evaluated as we go along.

Deputy Joe O'Brien: I urge caution. If we get stages 1 and 2 right, we might get that effort repaid later. I have a question regarding aviation. What will the landscape look like when it is possible to safely fly again? I refer specifically to infection rates and so on. Have officials thought about what restrictions might be needed both with respect to airlines and airports?

Mr. Jim Breslin: There are many levels to what the landscape will look like. The first element is the willingness of the public to travel and there will be anxiety on the part of members of the public for a considerable period. The European authorities have worked with the airline industry to devise procedures for those who must travel and physical distancing and other elements can be put in place around that. Ultimately, this will be based on national authorities making an assessment of where they are with their public health strategy and moving between phases in the extent of opening facilities. That may involve different arrangements in different countries. Some countries are very much in the take-off phase currently. Examples are in South America and eastern Europe etc., and people would be much more reluctant to have an arrangement for reciprocal travel in those cases than if we were all successful in suppressing the virus, for example, and where two countries had very low levels of community transmission.

Deputy Duncan Smith: I apologise as I was attending a meeting of the Business Committee and missed some sessions. I apologise if my questions are repetitive.

The advice from NPHET to the Minister on the passenger locator form and self-isolation was made on 3 April. That is two months ago, which is a long time in the context of this pandemic. What level of communication has there been with NPHET and the Department of Health on this specifically since?

Mr. Jim Breslin: There has been a great deal of discussion. Officials on NPHET are on the staff of the Department. The first action was to put the passenger locator form into place, which was done speedily; it was first done on a voluntary basis and then last Thursday we introduced it on a mandatory basis. That was to address the fact that the compliance rate was running at approximately 70% and we have full compliance now. As I said earlier, we are still at about 1% of the normal levels of overseas travel into the country, so we believe it is timely to be at 100% compliance. There is further discussion under way, not just within the Department and with NPHET but also with other Departments relating to the 14 days self-isolation period, with a view to going back to Government with a review of that and decisions being made.

Deputy Duncan Smith: I thank Mr. Breslin. I will direct my next question to Ms Graham of the National Transport Authority, NTA. I am getting a number of representations from taxi drivers and taxi drivers' groups on where they stand in this unwinding process. Will Ms Graham give me an indication of the kind of engagement that has taken place with taxi drivers regarding their responsibilities and the supports that will be given to them? In particular, if we are talking about aviation, Dublin Airport is poorly served by public transport compared with other international airports. Having a functioning taxi service is vitally important. I would appreciate any insights Ms Graham might give on that.

Ms Anne Graham: I am sorry but I have to disagree with the Deputy that the airport is poorly served by public transport. We believe it is well served by bus transport, certainly not by rail but we are working on that.

In terms of the measures the NTA has taken to assist the small public service vehicle, SPSV, sector, we have had extensive engagement with the industry, both individually and through our website, providing advice and assistance on all aspects of operation and temporary deferral of activities. We have deferred renewal dates of vehicles due to renew by three months, from 13 March to 12 June. That will be reviewed in line with the SPSV suitability inspection centre reopening. We have got a new regulation in place to enable the operation for a further 12 months for those vehicles that would reach a final date of operation between 13 March and 31 December 2020. We have provided advisory guidelines on temporary Covid-19 dividing screens. We have also engaged with the insurance providers and facilitated cover reductions to private or foreign theft cover only for parking up of the SPSVs. We have done as much as we can in terms of our remit and the legislation we have in place. We continue to engage with the SPSV sector. We are very much aware of the impact this pandemic has had on the industry and we will continue to work with those in it to provide as much support as we can do.

Deputy Duncan Smith: I thank Ms Graham. In terms of the increase in services for Dublin Bus and other bus providers, will there be increased communication over the next few days in advance of the next phase next week?

Ms Anne Graham: We are planning to increase services for phase 2. There are decisions the Government has to make relating to whether it will move to phase 2 but what we are doing is putting in place all the plans and services necessary to provide some additional capacity on our bus services from next Monday.

Deputy Duncan Smith: I thank Ms Graham. If I may direct a final comment to Mr. Burgess, Ireland has always had a very good reputation for not pulling up the ladder on countries that are not as wealthy as we are here. It is nice to see that that is being maintained through this unprecedented crisis. What Irish Aid is doing is laudable and I want to pass on my congratulations and well wishes to the Department in that regard.

Mr. Niall Burgess: I thank the Deputy.

Deputy Cian O'Callaghan: I have a question for Ms Graham. In terms of the current position, pre-crisis public transport at peak times was heavily congested with packed buses and trains. It is clear that there will not be a desire on the part of passengers to return to those sorts of services in the future. There has been a major modal shift in terms of people moving towards cycling in particular. I cycled in here today. In terms of that modal shift, in recent times the numbers one sees cycling, certainly in my constituency, are unprecedented. The mobility plans and the emergency funding are very welcome. I strongly support that but are there any plans

to front-load or fast-track cycling infrastructure in particular that is in the pipeline and will be built in the next few years anyway? That is where we are moving to in terms of climate change and everything else, but if the funding was available, are there projects currently in the pipeline that could be brought forward and implemented faster?

Ms Anne Graham: That is the work that is ongoing with both Dublin City Council and the other local authorities. It is to identify projects that can be put in place on a temporary basis, those that are planned and are part of the cycling or walking networks that are part of our transport strategies for all cities. Where possible, if local authorities can identify a space where a temporary barrier could be put to provide additional walking and cycling space, we want to receive those proposals so we can move as quickly as possible to put them in place. Dublin has started with the Liffey quays on the northside and a number of other projects such as that on Nassau Street. We want to see more and as much of those as possible put in place, particularly before we move into the later phases of the easing of restrictions.

Deputy Cian O'Callaghan: The approach of temporary and emergency measures is the correct one, and the work that has been done and is being done is commendable. Beyond that, is permanent infrastructure in the pipeline or in the planning process? Is the capacity there, if funding is made available, to speed up the delivery of some of that long-term permanent infrastructure? That is what I am really asking. Has an analysis been done of what could be brought forward?

Ms Anne Graham: Our first approach has been to do the emergency response, and we have to focus on that with the resources that we have. We have a dedicated cycling design office in place that had been working on more permanent plans, encouraging more permanent infrastructure, and bringing as many of those plans through the planning process for future funding; however, we have had to naturally divert to temporary crisis measures. We hope to move back to the more permanent measures and bring those plans forward as quickly as possible, but they will have to go through a planning, design, construction and tendering process.

Deputy Cian O'Callaghan: There will be a growing demand to use personal electric scooters. Does Ms. Graham have a view on what needs to be done in terms of facilitating that?

Ms Anne Graham: There are legislative issues around the use of electric scooters and that is being looked at by the Department of Transport, Tourism and Sport. It is not really our area to regulate, but the Department is looking at that.

Chairman: Thank you, Deputy O'Callaghan. I call Deputy Boyd Barrett.

Deputy Richard Boyd Barrett: There are many issues impacted by Covid-19 in terms of transport. I do not have time to address all of them but as a general remark, while social distancing and Covid-19 is around, if we are going to maintain our public transport system it has to be on a not-for-profit basis. It will not be commercially viable, but we cannot do without it. We have to move to a not-for-profit approach. On aviation, we need to reconsider renationalising what used to be the national airline in order to maintain air infrastructure.

The main questions I wish to ask are about the taxi industry, which was briefly referred to by Ms Graham, but really it has been addressed in a cursory way. In response to a request sent through me from the four taxi representative groups, the Taoiseach said he would ask the Minister for Transport, Tourism and Sport to meet these groups. I have still had no reply from the Minister. That is not Ms Graham's issue, I want to state that for the record. He should answer

and agree to meet the four taxi representative groups because they are facing absolute devastation. I would urge that it is the case and I hope our committee would support that call. They are in serious trouble for all the obvious reasons. The crucial thing that has to be discussed is a roadmap and financial package of supports in order to keep the livelihood of taxi drivers sustainable.

I have some questions for Ms Graham. All licences that expired before 12 June for taxi drivers have an extension of three months. What happens to licences that expire after 12 June? Taxi drivers need certainty, they should have the extension and be given that commitment and certainty. The NCT and suitability tests need to be done in order to get a licence. Given the financial hit that taxi drivers have taken would Ms Graham consider not charging for those? Could she tell us whether NCT and suitability tests could be done together rather than separately, which used to be the case? Can taxi drivers who choose to try to get back to work be prioritised for those tests? Regarding the state of the taxi industry, has Ms Graham information on how many taxi drivers are on the Covid-19 payment? Can she tell us how many are old-age pensioners over 66 who may be working but are not entitled to the payment?

A driver can suspend a licence for a year, but after that they have to pay a €500 reinstatement charge. While the public health situation remains uncertain, drivers may wish to suspend their licence for a longer period. Could that charge be waived, to give them some support? Also, could the ten-year rule for the age limit of cars be changed to a 15-year rule? Again, this is because of the financial cost that will be incurred by taxi drivers in replacing their cars after ten years, given that they are going to be in deep trouble.

Finally, there are no clear guidelines or support for taxi drivers in terms of health, or for standardised screens. There are also insurance issues. Could Ms Graham comment on that because it is a serious concern for many taxi drivers?

Ms Anne Graham: There are quite a number of questions there. We have indicated that we have extended all licences by three months until 12 June and we will review that in line with the SPSV suitability inspection centre reopening. We do not have an indication of when that will be or when the NCT centres will reopen. We will align our possible extensions with when the testing can be done but we are awaiting dates for when the testing centres will be available for taxi drivers. We will of course work with the test centres to try to get priority for tests to ensure that we can get as many taxi drivers as possible back into the system.

I do not have any information on the Covid-19 payment, that information would not be held by us. It is a Department of Employment Affairs and Social Protection payment and we do not have any information on which SPSV drivers have availed of that.

On the reinstatement, I might get back to the Deputy on that if he does not mind just to tease out a bit more what exactly he is asking there.

On the ten-year rule, we went out on consultation on an extension for one further year and that is what was agreed with our board. We will bring that back if the taxi drivers want to consider a longer rule. We prefer to extend it by just one year but, certainly, all of these things can be considered at any time.

We have outlined comprehensive guidelines on our website; it is very difficult for us to give very clear guidance on screens because of the different types of vehicles that are used by the SPSV sector. We have put in place guidelines on our website based on the public health advice.

Chairman: I thank Deputy Boyd Barrett. Regarding the matter which Ms Graham said she wanted to tease out with the Deputy, would she be prepared to do so by correspondence?

Ms Anne Graham: Yes.

Chairman: Thank you very much. I call Deputy Tóibín.

Deputy Peadar Tóibín: One of the most controversial decisions made by the Government around the handling of Covid-19 was on international travel because it is obvious that international travel seeded the virus in Ireland. At the time, many countries were stopping international travel. New Zealand is probably the best case in point. It prevented much of the virus coming into the country. I remember asking the Taoiseach why he would not stop flights coming in from northern Italy. He said that it was the advice of the European Centre for Disease Control, ECDC, that we not stop travel within the European Union. My instinct at the time was that this was a decision being made around the European Union's movement of people policies, rather than the health of the people. It was a wrong decision and has obviously led to a higher number of fatalities in this country *per capita* from Covid than many other countries who locked down their borders at the time. In that regard, I note from the Department's presentation today that NPHET gave the advice to the Government on 3 April that there should be mandatory self-isolation for international travellers. It is shocking that mandatory filling of forms for international travellers was only introduced last Thursday. Once that form is filled, international travellers can come to Ireland and have no legal responsibility whatsoever to self-isolate. I ask the Department of Health's representatives why we are not making it legally mandatory for these individuals to self-isolate as other normal liberal democracies have done around the world.

That is the first question. The second question concerns another example where the Government deviated quite radically from the medical and scientific advice it was being given, namely, the advice relating to seasonal workers. At the time, I raised the issue that we had international seasonal workers arriving in Ireland to work on fruit farms and yet we have a bizarre situation in which Irish soldiers cannot return from abroad because of restrictions. At the time we had the Chief Medical Officer, Dr. Tony Holohan, state it was against best public health policy to have seasonal workers travel around the world in a pandemic and yet, today, seasonal workers can travel to Ireland without any restrictions.

I ask these two questions initially of the Department's representatives. Why has the Department deviated from best medical advice in those two areas?

Mr. Jim Breslin: I do not know that we have deviated. I need to be careful, as outlined in the introduction, that as a civil servant I am not commenting on the merits of Government policy one way or another in trying to give the context in which this was done.

The Deputy is correct that the ECDC stated border restrictions are, other than in very extreme situations, seen to be ineffective. The countries in Europe that imposed them were not able to prevent the virus entering the country.

Deputy Peadar Tóibín: Those countries that restricted international travel did a lot better than Ireland.

Mr. Jim Breslin: I do not think that is the case. We would have to go through them one by one but, for example, Italy had restrictions on Chinese travel from the off and probably had complacency on the issue as a result of that. In relation to New Zealand, it is a very different

case. They are a long way from anywhere. We are right in the middle of a common travel area and the European Union with intense----

Deputy Peadar Tóibín: I do not want to interrupt and I apologise but my point, which Mr. Breslin makes in his own statement, is that NPHET gave the advice that there should be mandatory legal self-isolation for international travellers for the first 14 days. That has not been implemented by this Government two months later. We also have a situation whereby we were told by the Chief Medical Officer that the movement of seasonal travellers was against public health policy and yet it still is occurring.

Mr. Jim Breslin: In all those cases, the Government has to work through the various pieces of advice it has, including our international obligations and domestic, legal and constitutional issues. That is what the Government has asked the Minister for Health to do in relation to mandatory self-isolation. There is a process under way in relation to that. It remains the case that travel into the country is very low, at 1% of the normal rate.

Deputy Peadar Tóibín: On public transport, I have a quick question to ask of the representative of the NTA. What will be the cost to the public transportation system of the reduction in traveller numbers in the system in recent months? What will be necessary to pump into that system for the rest of the year to make sure that the capacity, the number of buses and the timetables are adhered to?

Ms Anne Graham: It is very difficult to give a definitive figure to the Deputy because it depends on the response of the Government over the next number of months in terms of social distancing and the response of the public in terms of returning to public transport following, hopefully, a full easement of all restrictions. Fare revenue covers approximately 65% of the cost of operating public transport. If 80%, or a good proportion, of that is lost, it represents a significant shortfall in public transport service provision and covering the cost associated with that.

Deputy Michael Collins: I thank the Department of Foreign Affairs and Trade and the NTA. I have questions that could go on for an hour but I only have five minutes. There may have to be correspondence at a later stage. I pay tribute to the Department of Foreign Affairs and Trade, the staff in the Tánaiste's office and the people who helped my staff and myself. These people were on the phone 24-7 following our first call trying to get constituents in Cork South West out of Bolivia, and were engaged in the massive efforts to charter a flight to get more of our constituents from Peru. A massive effort was put into getting people back from Peru in particular. Putting all these pieces together to bring young people back home to very worried parents was a logistical nightmare, especially when Peru was officially closed. The Department provided us with information about available routes and connections for the doctors and nurses stranded in Australia, and made sure our constituents had seats on those flights. Information was provided to us and we were able to update our people in America, New Zealand, Denmark and Spain, and many other places, ensuring that people got home safely. I also thank the Department and the Tánaiste's office for helping us with emergency passports, again ensuring that our people were able to get back to work and get back to where they needed to go. The professionalism and the communication from the Department was very much appreciated by myself, my office and those who so desperately wanted to get home. I pay tribute to the Tánaiste and Minister for Foreign Affairs and Trade, Deputy Coveney, who had to intervene to ensure the safe homecoming of so many.

Now that circumstances are improving, we need to open our ports and airports. It is time we

followed places such as Singapore with same day testing and results for everyone coming into the country, giving them the freedom, once results are received, to travel and enjoy our beautiful country. Do the witnesses see this as being part of the reopening of Ireland? If so, when do they think it can be put in place?

Following the outbreak of Covid-19, Ireland has repatriated 6,000 citizens, with approximately 1,000 still waiting to get home. Why have we had to rely on other countries to get our people home when countries such as Malta has its own military airlift transport?

Chairman: To whom is that directed?

Deputy Michael Collins: To the Department of Foreign Affairs and Trade. The HSE might also answer the question on same day testing.

Mr. Niall Burgess: I will take the question on repatriation. We are working with approximately 1,000 people to get them home. Those are widely dispersed in all the regions that we already repatriated people from. We have relied very heavily on international co-operation to bring people home as quickly and effectively as possible. We accessed a European Union mechanism. The EU has repatriated close to 600 Irish citizens in an arrangement whereby we all work together to repatriate our citizens. We have worked with the UK, the US and Canada. We have also repatriated citizens from other countries. That network of international co-operation that has worked very well. We have not needed to draw on other resources to bring people back.

Chairman: Does the Deputy want an answer on testing at airports?

Deputy Michael Collins: Yes, if it is possible to get that answer.

Mr. Jim Breslin: I mentioned testing earlier. The ECDC advice is that the evidence base for that testing is unclear. The PCR test does not detect the virus at all stages. The incubation period is between two and 14 days so a person could be a few days into the virus without the virus being present in his or her respiratory tract or nasal passage. They consider when they get symptoms that they are Covid-free when in fact they are not, so there are difficulties with implementing that type of an arrangement because before travel or as people arrive in the airport they could have contracted it en route but still not be shedding virus and be capable of being detected by the PCR test.

Deputy Michael Collins: I thank Mr. Breslin. Time is running very tight. My next question is for the NTA. Private bus and coach operators are facing ruination and that will have major implications for us down the line. Are there any plans to get direct Government support or will there be a continuation of the wage subsidy scheme until the tourism transport sector returns to normal? Is it intended to provide Government grants to assist liquidity or to restore the fuel rebate? Are there any plans to reclassify the VAT status as per the situation that exists in Northern Ireland? Basically, are there any plans for the survival of bus and coach operators?

Ms Anne Graham: Many of the proposals have been put forward to the Department of Transport, Tourism and Sport and they are under consideration. The commercial bus sector is an important part of the delivery of public transport across the State and we want to see it supported and for it to recover back to operating. The suggestions put forward by Deputy Collins have gone forward to the Department for consideration.

Deputy Stephen Donnelly: As I have thanked Mr. Breslin and his team many times, I

take the opportunity to thank Mr. Burgess and the staff at the Department of Foreign Affairs and Trade. I also thank Ms Graham and the staff of the NTA. I know their people have been working around the clock and have put in extraordinary work and I want to recognise that work.

This question is for Mr. Burgess. I will start with the 1,000 citizens who are still waiting to come home. Several thousand are now back but it is concerning that 1,000 citizens around the world are still trying to get back and are not here. Could he give a quick update on when we hope to have them home and if any are in particularly urgent circumstances that require faster action?

Mr. Niall Burgess: There are always some citizens who are in urgent circumstances and with whom we are working particularly actively. It is very difficult to get a precise fix on the numbers of people who want to come home because people's assessment of their circumstances changes continuously. We had a very high caseload, for example, from New Zealand, but as the health situation there improved several citizens decided that they would be better and probably safer staying in New Zealand than taking the risk of long-haul travel.

At the moment, we have clusters of citizens in Latin America, especially in Argentina and Brazil. We have numbers wanting to get out of Brazil because of the evolution of the disease there, and it is particularly difficult because of the reduction in international traffic. We have clusters in Nigeria and in South Africa. We also have clusters in Asia, including Bangladesh.

Deputy Stephen Donnelly: Could we not charter flights to get them out?

Mr. Niall Burgess: We charter flights where we have a large number of citizens in one place or where we can bring citizens together to one place, but in many cases these are either small groups or they are quite widely dispersed. In those circumstances, working with other partners is often the most effective way of getting people back.

We also have a very significant number of people in the Canary Islands. Many of them are elderly and they are looking to come back in order to have health checks. Because flights are regularly posted and seats are posted for sale, they sometimes develop a false sense of security that they have a flight booked for 3 or 4 May and when the flight is cancelled then the frustration sets in. We are looking in particular at a cluster in the Canary Islands at the moment and we are urgently trying to get them back.

Deputy Stephen Donnelly: In the interests of time, there is one more question I want to ask so I will stop Mr. Burgess there if I may.

This really is a question for whoever the responsible body is. I have had a lot of people contacting me asking what the situation is on incoming travel. We understand that there are no restrictions on people going between the North and the South, but if people are flying in from Britain do they need to isolate themselves for two weeks? While there is now enforcement in terms of signing the forms, people are asking what happens after that. Is there anyone following up to check that people are isolating? If they isolate with friends or family, do the friends and family have to isolate, or do they essentially have to sit in their friends' house for two weeks while their friends go about their business? Is there any enforcement in terms of what happens when people leave the airports after they sign forms? When do the witnesses believe these requirements will be eased? I have read through the roadmap, which states that, for all five phases, "Specific measures will be introduced at ports and airports.". I cannot find any statement indicating that the two-week isolation requirement will be waived. However, we

know the requirement will be waived in Italy tomorrow and in other European countries in the next two or three weeks. I apologise to the Chairman for finishing with a very broad question.

Mr. Jim Breslin: On the position with overseas travel, which includes Britain, the public health advice is that there be a period of 14 days self-isolation. People travelling from Britain into Dublin Airport, for example, will be required to fill out the passenger locator form, including their intended address for their stay. If they were to change that address during the course of the 14 days, they will be required to update it. They will be subject to checks over the course of the 14 days - at day 2 and day 12 - to confirm that they are in the location they have declared. That is the current arrangement *vis-à-vis* travel from Britain.

Chairman: Public advice was mentioned. As a matter of law, is there any requirement?

Mr. Jim Breslin: No. The requirement is to fill out the passenger locator form and it is an offence not to do so. It is also an offence to give wrong information or fail to update the information given. However, there is not a statutory regime of 14 days self-isolation, just as there is not such a regime for those in the country. As I said earlier, the Minister for Health has been asked by the Government to look at that and come back.

Deputy Stephen Donnelly: When should this measure be relaxed?

Mr. Jim Breslin: I do not have a firm view at this stage. We would have to see a number of things happen. We would have to see that we control the virus and community transmission. We would want to see a very narrow differential between the experience of countries from which people are travelling and our experience, such that those countries have the same experience of the disease as we do.

Chairman: I thank Mr. Breslin. Is Deputy Colm Burke speaking for five or ten minutes?

Deputy Colm Burke: I will speak for ten minutes. I thank the witnesses for their presentations and for all of the work that has been done in recent months. I dealt with a number of cases where the Department of Foreign Affairs and Trade was of great assistance, in particular, involving people who were in Nepal, which is not the easiest place to get in or out of. As a result of co-operation between the Department and the European Commission, people were able to travel back to their homes.

What arrangement is in place for people who take a flight or ferry into Northern Ireland intending to travel to the South? Do they have to fill out forms in Northern Ireland? If so, is the information conveyed to the authorities in the South? Are there ongoing discussions on that issue, particularly with regard to people who decide to fly from South America to London and on to Northern Ireland, intending to spend a few days before travelling south?

We have peak hours for public transport because people need to travel to start work at 7 a.m. or 8 a.m. That may change completely if companies decide to introduce shifts of, say, 6 a.m. to 2 p.m. and 2 p.m. to 10 p.m. Have discussions taken place with the public transport authorities on changing schedules to provide a higher level of transport when workplaces start to open up again? What discussions have taken place with employers and public transport companies?

What arrangements are in place to meet the requirements of pilots and airline staff who travel in and out of Ireland? What process have we put in place for them when they come in here, in particular, if they have been in America or other places where there is a high incidence of Covid-19? I am wondering if there have there been any discussions with the employers

about what they are doing to facilitate their staff.

Chairman: Does anybody wish to respond?

Mr. Jim Breslin: I could take the last one, if that's all right.

Chairman: Thank you, Mr. Breslin.

Mr. Jim Breslin: Regarding pilots and airline staff, in which group I would also include transport workers, hauliers, etc., the advice is not that they have to self-isolate. It would be impractical if they had to take 14 days every time they travelled over and back. The advice is very much to work with those sectors to put in place good public health practices so that they minimise their risk of exposure. We have worked with the Department of Transport, Tourism and Sport to do that in those sectors.

Senator Colm Burke: What about work with the airline companies and the ferry companies on what additional supports they are providing to facilitate staff when they arrive back home?

Mr. Jim Breslin: The sectoral approach on which the Department of Transport, Tourism and Sport has worked with road hauliers, airlines and sea transport has been very much that each of those sectors would put in place good practice to support their workers to maintain their health throughout the process.

Senator Colm Burke: I refer to the need for public transport. There may be different peak hours now. Has there been a discussion on that? It may not be Mr. Breslin's area. It may be for the National Transport Authority.

Ms Anne Graham: I can respond to that. In terms of public transport, what we have seen is that the pattern of public transport usage has changed in recent weeks. Particularly, we have seen a much earlier peak in the morning associated with essential workers travelling earlier, and obviously also construction workers travelling. We have seen the peak between 6.30 a.m. and 7.30 a.m. whereas normal peak would be 8 a.m. to 9 a.m. We have also seen a peak at 3 p.m., which is not something one would normally witness on public transport. Usually, we have high peaks in the morning and a lower peak in the evening. That, I suppose, shows that we have many more shift pattern workers travelling on the public transport system.

In terms of what we can do, we engage closely with the public transport operators. At present, our Luas light rail service in Dublin is fully operational. There is no additional capacity available to operate Luas. We can provide additional capacity on our bus and rail systems but it is limited to an additional 20%. Then one needs to take off the 80% for social distancing.

There is no doubt there is limited space available on our public transport system with social distancing in place. However, we are encouraging more people, particularly office workers and those who can work from home, to continue to work from home to allow the available space to be used for those essential workers who cannot work from home. We are also looking to encourage the staggering of opening hours, particularly for retail coming back into operation because that would also ease and allow for the peak to be spread, both in the morning and in the late evening.

We will continue to engage with employers to encourage work from home, and where one must make a trip, if at all possible to make those trips locally and walk or cycle where possible

to take the pressure off our public transport system.

Deputy Colm Burke: I also asked about people travelling into Northern Ireland.

Mr. Niall Burgess: There are several categories of traveller involved. Passengers coming into Ireland from overseas are required to fill out the contract tracing form. People who cross the Border from North to South are not required to do so. People entering Northern Ireland from abroad are bound by the UK advice to travellers and by any restrictions that apply to them. Regardless of whether one is north of the Border or south of the Border, one is expected to observe the public health advice that applies in that jurisdiction.

Deputy Colm Burke: Is there any process in place to convey the information gathered in Northern Ireland about a person coming into that jurisdiction who clearly indicates that he or she is travelling to the South and who undertakes to self-isolate in the South?

Mr. Niall Burgess: No. If somebody is coming into Northern Ireland from somewhere other than the UK, he or she is required to isolate for a period. If someone has travelled from Great Britain to Northern Ireland and then travels to the South, they are not obliged to notify anyone of that.

Deputy Colm Burke: I know but is there a process in place to exchange information with regard to people who travel to Northern Ireland from outside the UK before travelling to the South?

Mr. Niall Burgess: If people are travelling to Northern Ireland from outside the UK, they should be isolating. We have not, however, imposed any additional restrictions on travel across the Border because the basic thrust of our policy is to ensure that cross-Border communities can continue to function and that maximum mobility is enabled.

Deputy Colm Burke: Is there any process in place to share information?

Mr. Niall Burgess: There is continuous co-ordination between the chief medical officers in the North and South, between the health ministers, and between our Government and the Executive at several levels. I would have to defer to my colleagues from the Department of Health with regard to the sharing of health information.

Mr. Jim Breslin: I will ask Mr. Ó Conaill to come in on that issue.

Mr. Colm Ó Conaill: With regard to contact tracing, the first case on this island, which arrived here in late February, involved information shared with the North by the South. If there was a case of an Irish person coming to the South via Northern Ireland, this would not pose a problem. That situation is provided for under the international health regulations. The issue of a standing arrangement for the sharing of information is being looked at as part of the process of mandatory self-isolation that is under way. Interdepartmental discussions are being held. We are in very regular contact with the authorities in Northern Ireland, including via the offices of the respective chief medical officers, which Mr. Burgess mentioned.

Deputy Colm Burke: There is no process in place at the moment.

Mr. Jim Breslin: The UK authorities are instituting their arrangements as we speak. They will move towards a revised arrangement in the coming days.

Deputy Pearse Doherty: In response to Deputy O'Rourke's question regarding those

who had booked holidays for later in the summer, Mr. Burgess mentioned that the advice may change. Is that a signal to people who have holidays booked for late August that they may still be able to travel abroad for those holidays?

Mr. Niall Burgess: No, it is not. Our advice is essentially aimed at protecting the health and welfare of Irish citizens both when travelling and when abroad. Our advice evolves in light of the public health advice. I would not want to send a signal because I do not know how the advice will evolve over the coming months.

Deputy Pearse Doherty: From the Department's point of view, although Mr. Breslin may also wish to answer, what are the triggers or what criteria will need to be met to allow for people to travel? What would need to change for people to be able to take the holidays they may have booked for late August?

Mr. Niall Burgess: The public advice here would need to evolve to a point where we were not advising people against travel off the island. That is the first criteria. The second factor we would look at is the public health situation in the country where people were planning travelling to. A third factor would be a sense of the safety of international travel. Essentially we are talking about a situation that is unprecedented and rapidly evolving. In the first three months of last year, we updated our travel advice on 130 occasions for different countries. In the first three months of this year we updated our travel advice 1,300 times. This is a tenfold increase and is because of the speed at which a local public health situation was evolving. It can evolve very rapidly. One can have a situation where the authorities in the Republic of Korea open up to international travel and then a few days later they impose restrictions around Seoul. It is very difficult to imagine a stable situation in the coming months where we will be able to give travel advice with a degree of assurance.

Deputy Pearse Doherty: When Ryanair, Aer Lingus and others are saying that half their flights will start up again on 1 July, does Mr. Burgess expect the advice from the Department to be that no non-essential travel be undertaken?

Mr. Niall Burgess: The advice is that no non-essential travel should be undertaken, which is the advice that runs through the five phases. Until the start of phase 4, the advice is that no travel beyond a 20 km limit be undertaken. This is where our advice rests at the moment.

Deputy Pearse Doherty: With regard to the locator forms, who makes the call and follows up to check on whether people are self-isolating?

Mr. Jim Breslin: Currently it is staff in the border management unit, under the Department of Justice and Equality.

Deputy Pearse Doherty: Does Mr. Breslin know how many staff are in that unit?

Mr. Jim Breslin: I do not know. It is not in my area, but one of the features of it is that there is so little throughput currently. As I mentioned earlier, there is just 1% of traffic through. Basically all of those staff are available to do that now.

Deputy Pearse Doherty: How many calls are done weekly?

Mr. Jim Breslin: The numbers of people coming through are very low. By and large when we look at the data, it is Irish people returning to Ireland. Mr. Burgess spoke about repatriation and much of that is still coming through. Some essential workers are coming through, but the

numbers of people, compared to what we would be used to, is very low. It is down to 1% at this stage.

Deputy Pearse Doherty: I cannot remember where I heard it, and I am not sure if it is correct, but I thought that the border management unit had only 50 or so staff. Is that within the ballpark?

Mr. Colm Ó Conaill: The border management unit is under the Department of Justice and Equality so I do not have exact figures on the number of staff there. For a rough ballpark figure 1,400 calls are made per week with regard to passengers coming through Dublin Airport.

Deputy Pearse Doherty: How does that compare with the fact that 11,000 passengers have come through in the three weeks between 1 May and 23 May, with 33% of them being exempt? That is 2,500 calls that should have been made per week. Are 1,000 people being missed every week?

Mr. Colm Ó Conaill: I am reading from data made available to us by Department of Justice and Equality colleagues. It is not our area, we are not collecting the data and we are not making the calls. It appears, from my understanding of the information we have been given, that one is dealing with calls being made to all non-exempt passengers. If passengers are exempt, and there are certain grounds for exemption, then they are exempt. If passengers are not exempt from the forms, then calls are made. Successful call rates are running at approximately 66%. The balance, obviously, are unsuccessful calls. A second call is made then, as Mr. Breslin mentioned, 12 days after entry to the State. That is the arrangement and they are the-----

Chairman: Mr. Ó Conaill said calls. Is that a visit or a telephone call?

Mr. Colm Ó Conaill: It is a telephone call.

Chairman: Presumably it is a mobile call if it relates to visitors coming into the country.

Mr. Colm Ó Conaill: It could be a mobile phone or a landline.

Chairman: If it is a mobile phone, how does the Department know where somebody is when it phones him or her? Does it just ask the person?

Mr. Colm Ó Conaill: Exactly, yes.

Chairman: I thank Mr. Ó Conaill.

Deputy Pearse Doherty: What if somebody says, on the second day of the two-week period, that he or she was down at the beach with his or her family for the weekend? What would happen there and what would be the protocol?

Mr. Colm Ó Conaill: That is a matter for the border management unit and An Garda Síochána. As far as I understand, they have worked out arrangements. From figures we have relating to the forms, a very high percentage of people say they are at the location where they have said they will be. That is for the calls that get through.

Deputy Pearse Doherty: I turn to Mr. Breslin in respect of the restrictions and the discussion relating to mandatory isolation, given that this is just guidance at the moment and there is no requirement on somebody to self-isolate, despite NPHET recommending that two months ago. Will that happen or is the idea of mandatory isolation finished? Mr. Breslin stated it is be-

ing looked at in a number of Departments but is serious consideration being given to mandatory isolation, with people being detained if they do not want to self-isolate? Is that the appropriate position, given that many other jurisdictions are reducing or releasing their restrictions and going in the opposite direction to us?

Mr. Jim Breslin: The issue is receiving detailed examination, although I do not know about serious consideration. The decision, ultimately, will be made by the Government. The work is being done not because the decision has been made but to inform the decision that will be made.

Deputy Pearse Doherty: Has Mr. Breslin any indication of when that decision will be made?

Mr. Jim Breslin: I expect the work to be completed within the next couple of weeks.

Deputy Pearse Doherty: As an indication to the wider sector, and I fully agree we have to be guided by the public health advice at all times, I turn to the requirement to self-isolate for two weeks on entry to the State regardless of which jurisdiction one is coming from or whether the virus there has a lower R-nought rate than we have at that point. Does Mr. Breslin expect that to be the position until the end of the summer or the end of the year, or does he foresee corridors being opened between European countries, jurisdictions and regions that will allow for travel into the country without a two-week isolation period to follow?

Mr. Jim Breslin: A couple of points are relevant, including the Government's roadmap. As Mr. Burgess said, when one looks at the transport section and maps it out, non-essential travel is advised against for all the phases. There are interesting developments, however, including at European level. The EU has identified that we should have a common approach to the lifting of restrictions and that there is scope to partner with countries that have similar epidemiological experience. Obviously, people will not want to partner with a country where the virus is undergoing community transmission and is out of control, but if a country has it under control, it is possible that reciprocal arrangements could be put in place. That would involve checks and balances from the public health authorities on both sides. In saying that, I am speculating. We will have to see how it goes at European level and be informed by the implementation of the roadmap here and by keeping the spread of the virus low within this country.

Deputy Pearse Doherty: Has Mr. Breslin any idea of when we are likely to have sight of a roadmap in respect of the restrictions of entry into our jurisdiction? Given the low levels of support that exist in terms of grant aid, many people have asked me whether, while the tourism season is gone this year, it is gone for next year too. They say that if the restrictions continue, they will not be able to stay afloat. That is the kind of question they ask. Obviously, public health comes first over any economic consideration, but is there now a need to provide a roadmap for when these restrictions will be eased, if they are to be eased?

Mr. Jim Breslin: Nobody can give full certainty on this. A roadmap is very much a set of steps, the timing of which would have to be carefully monitored. In the first instance, while others have talked about people who might be considering booking flights, that would be premature. We are not at that stage. If people are talking about non-essential travel, and there may be a reason that somebody has to travel for essential purposes, entering into a financial commitment at this stage, when we face a number of phases and issues of uncertainty, would be premature and I certainly would not advise that. I would be advising what the Government is advising, that is, that we should avoid non-essential travel. There are steps along the road, however, including for the tourism industry. If, having contained the virus, we can keep it at its

low level, people will be able, as we move through the phases, to travel around the country for holiday purposes. We could see that, and it could be of significant benefit so long as we keep the virus level low. If we lose control of the virus, we will put all that at risk. In the period after that, there could be a relationship between this country and other areas of Europe in a similar position. It requires our experience and that of the other countries to evolve and for us to have a very low rate of transmission.

Chairman: I thank Mr Breslin. If there is time at the end, Mr. Doherty may contribute again. I am aware that he had another question.

Deputy John McGuinness: Listening to the scenario being painted for us today, it is clear to me that we are going to be in one serious economic mess all through this year and, indeed, next year. We now need to plan rapidly for the Irish tourism and transport sectors.

I am from Carlow–Kilkenny. As people were speaking and addressing questions, I could think only of its hospitality sector, from the smallest bed and breakfast business to the range of hotels, including Mount Juliet, which rely so heavily on tourists coming to this country. The number of people travelling to Ireland is down to 1%. Visitor numbers in Kilkenny Castle will drop dramatically and the businesses that rely on it will suffer seriously. That is what is being explained to us in stark detail today. The cancellations right across the sector are for both this year and next so there will have to be an urgent Government response if we are to keep afloat those that will be able to stay afloat beyond 2021. What is happening is quite shocking.

I have seen tourists who come to this country stop at Kilkenny Castle. They often come to Ireland through Europe in groups, including from Asia, and visit Kilkenny and various spots around it. What is happening is quite concerning. Whatever Government will be in power and those who are talking about Government formation would certainly want to consider this matter and devise a plan to rescue the sector.

Over 10,000 are employed in the coach travel sector. In addition, there are the various small bus operators that rely on tourism and the school bus operators. There is to be a frightening change to how they are going to approach their business. The operator of a 53-seater bus, valued at €350,000 plus VAT and requiring 80% capacity on any route, will now be able to carry only 13 passengers if all the regulations are applied. What is the plan to save the tourism sector? What is the plan to consider further the inclusion of the private sector on the public service obligation routes? Will there be 0% VAT? Will the private operators be allowed to reclaim the VAT considering the arrangements they had in the past? Will there be a refund of excise duty? These are all major questions that will have an impact on our economy and the finances of the State. I ask the witness from the Department of Foreign Affairs and Trade about international networks. I compliment Mr. Burgess, his officials and the Minister on their excellent response, and they are an example for others to follow in how they deal with matters immediately. What about the Department's networks? Are they engaging in order to try to have some sort of plan that is agreed within Europe and beyond in how to manage tourists? Will we see that type of plan emerging? If so, when will that happen?

There have been recommendations made to the Minister regarding transport. It was late April and May when representatives of the transport sector wrote to us and the Department but there is no plan there yet. There is an urgent need for a plan. The Department of Health did this with respect to private hospitals and so on. There is clearly an urgent need for a plan in order to save these sectors and for supports to be put in place immediately.

Mr. Niall Burgess: I will give two comments on tourism as far as the Department of Foreign Affairs and Trade is concerned. We are continuing to work very closely with Tourism Ireland, as we have in recent months around the framing of recovery for the industry. We know, as it does, how important reputation is in selling Ireland to visitors in future. A really important element in that will be perceptions of safety, which is where the assurances around public and personal health here will be connected with the regrowth of tourism here.

There are actions we can do and are doing in the meantime to ensure the industry is positioned for a rapid recovery. Some of those are around keeping Ireland in mind as people's concerns turn to international travel and it becomes-----

Chairman: Are you referring to people going to other countries?

Mr. Niall Burgess: Many societies have become more inward-looking and many people are not thinking about international travel. Even at the very start of this pandemic, much work was done around the greening initiatives, which were sustained through St. Patrick's Day not as a way of saying people should come to Ireland now but rather to indicate that Ireland is a good place to visit and will continue to be in future. Those are two important platforms for the future.

Deputy Mary Butler: I will turn to the matter of passengers arriving in the State. We know they are expected to self-isolate for 14 days. The necessity for this is obvious but practical problems arise for business persons and tourists entering the country as various European borders are opened. If a person decides to have a Covid-19 test and it is negative, is this sufficient to satisfy regulations governing the person entering the country? I am not sure if Mr. Burgess or Mr. Breslin will take that.

Mr. Jim Breslin: I will take that one. No, it is not sufficient. The normal public health guidelines arise and there is a period after which a person can be tested and the virus is not detected where that person might develop and shed the virus. It is not possible to just take a test and think a person does not have to do 14 days of self-isolation.

Deputy Mary Butler: I thank Mr. Breslin for clarifying that as the question has come up a few times. I also compliment the Department of Foreign Affairs and Trade on its co-operation, especially at the start of the Covid-19 pandemic. There were so many Irish people who wanted to come home and I made contact several times myself. The Department staff's professionalism in that contact was very much appreciated.

Mr. Burgess indicated in his opening statement that 1,000 citizens are dispersed across many countries, some in remote locations, with an interest in returning home. The Department is working with them to provide advice and help. I was contacted recently by somebody from Dungarvan who is now in Morocco. Does the help come in the form of consular assistance or is some financial aid still available for when airlines can move again?

Mr. Niall Burgess: Help takes many forms. In some cases it is simple advice and guidance and putting people in touch with people who can get them home. That is at the lower end of the spectrum. At the high end of the spectrum, it is an actual repatriation on an Irish Government chartered flight, and then there is a full range of situations in between.

We have been working with partner organisations as well in respect of people who are made vulnerable because they cannot come home or access supports. We try to give them advice or guidance or work with organisations that can support them in practical terms. We have earmarked some €2 million for support to those organisations. People who are stranded are par-

ticularly vulnerable. The whole objective of the exercise is to make sure that they are supported as best we can do so while they wait to come home.

Deputy Mary Butler: I thank Mr. Burgess. My next question is for Ms Graham. First, she said earlier that much of the public transport capacity intended to be used in phase 2 has already been used up by what are thought to be non-essential journeys. Does she believe that will be an issue when, hopefully, we move into phase 2 next Tuesday? Second, I believe a 55-seater bus can now carry 14 people adhering to social distancing measures. I know that, technically, this area does not come under Ms Graham's brief but what recommendations will the NTA be making in terms of school services and the practical challenges we face in transporting children to and from school, hopefully in September?

Ms Anne Graham: In terms of the transport capacity, we are planning to provide additional capacity for the phase 2 lifting of the restrictions but, even then, we will be trying to discourage non-essential travel and reducing even the non-essential travel that is happening now following phase 1. We are planning to have as much transport capacity as possible available to ensure that social distancing can be maintained at 2 m on our system. What we are trying to do is spread the load across the day to try to get people travelling at times they would not normally travel. Our advice is that if someone can do so they should continue to work from home and only make essential journeys, even for phase 2 of the lifting of the restrictions and if they do need to travel, they should consider walking or cycling as part of their journey.

We are not in a position to make any recommendations in respect of school transport services. Obviously, social distancing cuts across all transport services, including school transport.

Deputy Mary Butler: I thank Ms Graham.

Chairman: I have a couple of questions, one of which is to convey a query. I was contacted by a company which is developing a renal dialysis unit in a hospital in Ireland and it requires specialist engineers from the UK to travel to Ireland. The company is a little unclear as to whether those engineers are legally required to self-isolate for 14 days when they come here and then start working or can they come here and start working? I am aware that the public health advice is to self-isolate but are they legally required to self-isolate?

Mr. Jim Breslin: I will not give an opinion on the fly on a particular case but there are essential workers. They would include healthcare and engineering workers where the issue that they are engineering is an essential service to which specific arrangements apply. As long as they take precautions, they can avail of an exemption from the 14-days self-isolation requirement.

Chairman: My understanding is that the company has sought clarification and is unable to get it. Is there any place that this company, and companies like it, can get clarification on that point to ensure that Ireland can be clear on the matter? Even if it is as clear as mud to people who live here what they can and cannot do, that would ensure that at least people from abroad can be clear on what they can do.

Mr. Jim Breslin: Given that it is a healthcare service that is being maintained, the HSE would be in a position to advise on that.

Chairman: Can I ask the HSE representative if it has a unit or a contact point for such queries?

Mr. Jim Breslin: Equally, I am happy, given the Chair has raised it, to get some details and liaise with the HSE on it.

Chairman: Not on this specific case; this is just one instance. There are, I am sure, a number of companies that would like to find out what exactly they can and cannot do lawfully in Ireland. Is there currently a unit they can contact?

Mr. Colm Ó Conaill: To clarify some confusion, the Chairman asked if it was a legal requirement in terms of self-isolation at present. Self-isolation is the strong public health advice; it is not a legal requirement. When people come in to the country, the legal requirement concerns the passenger locator form. Both ourselves and our HSE counterparts are being contacted in the main by the Departments of Business, Enterprise and Innovation and Transport, Tourism and Sport, as well as other colleagues across Government. There is no single email address but we can come back with-----

Chairman: Just to be clear, it is not a legal requirement for anybody, even people who want to go to a stag party in Santa Ponsa and come back? It is a recommendation and not a legal requirement?

Mr. Colm Ó Conaill: As-----

Chairman: The legal requirement is to fill in the form, is that correct?

Mr. Colm Ó Conaill: As my colleague, Mr. Breslin, said in his opening statement and made clear, it is being looked at as a requirement for the Minister of Health, in co-ordination with colleagues across Government, to look at mandatory self-isolation-----

Chairman: I understand they will have-----

Mr. Colm Ó Conaill: It is not mandatory at present.

Chairman: They will have completed looking at it within a week, so we will know then whether they intend to introduce the legal requirement. Is that correct?

Mr. Colm Ó Conaill: It is intended that the interdepartmental discussions will be concluded and a proposal prepared within a week.

Chairman: Is it fair to say that for a person from the Republic of Ireland going on holidays and who flies out of Belfast and returns into Belfast, there is no requirement to fill in a form on arrival into the Irish State? Similarly, if one is from Northern Ireland and flies out of and returns to Dublin for one's holiday flights, there are no forms either.

Mr. Colm Ó Conaill: Yes. It is clear that passengers arriving from Northern Ireland are exempt from completing the passenger locator form.

Chairman: Is it fair to say the only place one cannot holiday, if one is Irish, is Ireland?

Mr. Colm Ó Conaill: Could you repeat the question?

Chairman: The only place one cannot holiday is Ireland.

Mr. Jim Breslin: I do not know, but I do not think so. Hopefully, that it will be the place we get to holiday. We are all hoping that is the case. Both our own arrangements and the fact that the UK is implementing arrangements for mandatory self-isolation would mean people coming

into those countries from outside the common travel area would face 14 days' self-isolation. That is the advice in our case at the moment and is shortly to be mandatory in the UK.

Chairman: Are we relying on the UK to bring clarity to the situation, given the success it has enjoyed to date?

Mr. Jim Breslin: I will not comment on the policy of another government, whatever about the current-----

Chairman: Deputy Foley referred to tourism. There are a number of self-catering providers where people come and stay. It is not like a hotel where they have contact with other people and there is an increased risk of disease spreading etc. In accordance with the roadmap, when can self-catering accommodation open up to inbound tourists? Irish tourists are bound by the kilometre maximum but tourists who are coming in to the country are not. When can self-catering tourist providers open up?

Mr. Jim Breslin: In respect of Irish people, at some point, subject to the roadmap and the lifting of the advice to stay at home but to stay within the country. Our advice at the moment in terms of non-essential travel into the country is equally relevant. Until that changes, the Government would not encourage people to travel into Ireland for tourism purposes.

Chairman: Your message to people who are thinking about coming to Ireland for tourism is to stay at home.

Mr. Jim Breslin: Until our roadmap changes.

Chairman: At what phase will the message no longer be stay at home, but come to Ireland and enjoy, spend money, and sustain jobs there?

Mr. Jim Breslin: I can do no more than say what the roadmap says, otherwise I am looking in a crystal ball trying to-----

Chairman: What phase of the roadmap will it be that will enable people to come to Ireland from abroad and go to self-catering accommodation?

Mr. Jim Breslin: It will depend on our transmission of disease and what phase we are able to move to but it will also depend on where individuals are coming from. If they are coming from Brazil we would have a view on that. If they come from a place where they have succeeded in getting low transmission and have kept it stable, and we have developed a reciprocal arrangement, then that is something that may be possible at further phases. I cannot give any guarantees on that.

Chairman: I take it that it is not at any phase at the moment.

Mr. Jim Breslin: What we have said is that the assessment of that would continue to evolve over the course of the roadmap. The fact that the EU has put in place a framework for the lifting of restrictions is relevant to that. It was not available when the roadmap was first done.

Chairman: Okay, so it is not envisaged in any phase at the moment. It is not part of any phase right now?

Mr. Jim Breslin: It is not in any of the phases that we have currently.

Chairman: I thank the witnesses for answering my questions, and indeed the questions of

all committee members. I would like to thank the Department of Foreign Affairs and Trade representatives here in the Chamber.

I will suspend the meeting, provisionally until 9.30 a.m. on Thursday, until we confirm whether we are going ahead with the session then or not. If not, then we will suspend until next Tuesday at 11 a.m.

The committee adjourned at 6.35 p.m. until 11 a.m. on Tuesday, 9 June 2020.