Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session with Trade Union Officials on the Revised Departmental Spending Plans

28 January 2010

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Acting Chairperson)
Mr John McCallister
Mr Conall McDevitt
Mrs Claire McGill

Witnesses:

Mr Kevin McAdam	)	Unite
Mr Kevin McCabe	)	Northern Ireland Public Service Alliance
Ms Patricia McKeown	)	UNISON

The Acting Chairperson (Ms S Ramsey):

I do not know whether it is a good thing or a bad thing, but I have had to chair the meeting. The Chairperson and the Deputy Chairperson have made their apologies for their non-attendance, as have several other members. The Committee can hear evidence today, but cannot make any decisions. However, we can return to the subject in future meetings.

I know that you have been sitting in the Public Gallery. Thank you for the paper that you provided to the Committee and for attending this morning's meeting. Following your introduction, Ms McKeown, I will invite members to ask questions.

Ms Patricia McKeown (UNISON):

We sent you a paper within the deadline, but we issued an amended copy this morning to reflect the latest developments.

The DFP consultation paper asked Departments to allocate reductions on all the areas that you have covered with the Minister. There is no point in my repeating those. We visited the relevant websites, and the information is not there, so we base our presentation on what we know.

The paper includes a commitment to public consultation and an equality impact assessment. That is particularly essential in health-related issues. The Committee should satisfy itself that the consultation and the EQIA process will follow best practice and be fully compliant with the Equality Commission guidelines.

I am sorry that the Committee Chairperson is not here this morning, because I was dismayed at his public attack on the employment of equality officers in the Health Service. Last year, our arguments on the proper application of the equality laws of the land saved three Health Service residential homes in his constituency from closure. I cannot countenance how the Health Service could deal with the unacceptable level of health inequalities without a strong commitment to the promotion of equality of opportunity. That money is not wasted: spending on equality is vital.

The Committee must consider whether it remains appropriate for the Executive's priority to be the economy, as quoted in the DFP paper, given its consequences for health delivery. That is the main amendment that we made from the first paper that we submitted to you. This month's 'Health Service Journal' contains a powerful and persuasive article by Professor Kieran Walshe, who is the professor of health policy and management at the Manchester Business School. Our papers quoted three elements of his article that are of particular significance for Northern Ireland. The points are not new to us, because we have given evidence in such terms before, but Professor Walshe brings them together at an appropriate time.

He states:

"In some places, such as Austria and Germany, the government is planning to spend more on health and social care to stimulate their economies. They believe that health spending, because it results in domestic consumption and has economic benefits (like employing people) is a better stimulus than, for example, car scrappage schemes.

The richest countries of western and northern Europe, which spend the most on their healthcare systems, are probably well placed to protect them."

We spend the least, and that makes us vulnerable.

He goes on to say:

"Second, the economic crisis is likely to damage health. Crises in Russia, Asia and Argentina in the 1990s all show that rapid adverse economic changes result in a variety of difficulties, from alcoholism and mental health problems, to worsening access to acute care and rising morbidity and mortality."

We argue that that point is relevant here.

Professor Walshe's next point is also characteristic of our society:

"Data from past crises suggests that health problems result not because GDP falls, but because economic costs fall unequally on some groups — the unemployed, the elderly, unskilled workers, migrants, ethnic minorities and so on."

He contends:

"Governments can do a lot to mitigate adverse effects, by spending not only on healthcare directly but also on social programmes and education."

We presented that very argument to the First Minister and the deputy First Minister at the start of the economic crisis.

Walshe states that Governments:

"can keep people in work through labour protection schemes. The evidence from past crises suggests that investment in health, education, and social welfare should be what economists call 'counter cyclical' — so, in a depression, governments should aim to spend more, not less.

In making his next point, Walshe is referring to England:

"But, given the NHS is awash with rumours about savage cuts, perhaps the main message to be taken from other countries' experience is that crises should not be allowed to result in a covert shifting of costs onto individual patients, which would increase inequality and disadvantage, nor a knee-jerk cutting of healthcare funding and provision."

We pride ourselves on the fact that everyone in this society falls within the scope of a health and social care system that is free at the point of need. Not many societies can make that claim, and, indeed, it is done here with less money than most other places have.

"In an economic downturn, health spending represents great value both as a short term economic stimulus and for its long term economic benefits."

I am pleased that that kind of evidence is coming through, because it underscores what we have already submitted.

The Minister of Finance and Personnel considers health to have been prioritised because its budget will face a 2·1% cut rather than the average 2·6% cut that will apply to all other

Departments' budgets. However, a 2·1% cut in the health budget amounts to £113 million. The Committee should challenge the Department of Finance and Personnel to demonstrate the financial impact of those proposals. There is robust evidence that the Health Service is massively underfunded. There are deficits of 17% in acute care, 30% in children's services, including health and social care, and 35% in primary care, including mental health.

As we did not have full-blown evidence of the impact of the proposals, we reverted to evidence that we have already given to the Committee, through the Irish Congress of Trade Unions and UNISON. Every deletion of a Health Service post reduces our capacity to deliver healthcare in the face of underfunding and inequality. The slow and silent haemorrhage of care continues week by week, with clear evidence from our members that bed numbers are decreasing, waiting times are increasing and operations are being cancelled. The service remains fundamentally underfunded in comparison with need. Its outcomes remain substantially unequal, and its capacity for coping and making do is being stretched to breaking point.

Most of the easy options for savings, or the non-pay elements, are not being achieved. Some of those are being achieved, and you heard the Minister's evidence about generic drugs. However, many other elements are not being achieved. We proposed the policy option of the health budget being exempted from the comprehensive spending review. That is a precautionary, clinically essential approach, which would enable the Executive to consider the direction that our Health Service will take and come up with strategic solutions to the consequences of decades of failure to prioritise health needs.

The only route to long-term financial and service health is the prioritisation of inequalities and prevention. We provided extensive evidence in that regard in our last submission, but the demand for healthcare has grown immensely. Specific action in the areas of inequality can start to contain costs. We have called on the Executive to prioritise the statutory duty for the promotion of equality and to put the anti-poverty strategy on a statutory basis. That two-pronged approach could contribute to turning round a system that deals with ill health into one that focuses on well-being, health and social care, and that is what is required.

We think that the Committee needs answers — we know that we do — as to what baseline has been used by the Finance Minister. Is the baseline the one that contains the 3%, 3% and 3% year-on-year CSR cuts? Or will the last year be hit by the Chancellor's emergency statement of last

year, which would make it closer to a 4·5% cut? It is not clear to us from the DFP paper whether the £113 million is top-sliced from the 3%, 3% and 3% year-on-year or from the 3%, 3% and 4·5%. That makes a big difference, and we need that question answered.

As members know, there are three main components to the Health Service budget: ongoing commitments, inescapable growth and service development. We are very concerned, having heard some of the evidence, as service developments were very hard fought for in 2007-08. The Committee should ask where those key service developments are now and how the cuts will affect them. They included the major developments recommended by the Bamford review and the developments in the prevention of suicide and self-harm, cancer survival, care packages, cleanliness and cross-infection, and young people in care. I am very concerned: One departmental website announces that cuts will be accommodated by cutting the proposed new developments. That would have lethal consequences for the Health Service. The Committee needs to evaluate whether the DFP proposals affect the service development budget and, if so, to what extent; if they do not, what is their effect on on-going commitments and inescapable growth? Do we now make direct cuts to patient service delivery? Do we leave patients at risk because their patient safety improvements are not delivered? Our members can see immediately the effect of cuts on service delivery. They are not so immediately aware of what is happening in development and inescapable growth.

There are savings to be made in bureaucracy. UNISON's opposition to the commissioner/provider split is well documented; we are living with the additional transaction costs from that ill-judged move. The Committee needs to know how much is subtracted from the Health Service pound as it flows from the Department of Health to the Regional Health and Social Care Board, the local commissioning groups and then to the trusts. The question is straightforward. We do not believe that two sets of people are required to decide what need is and how to deliver it.

We encourage the Committee to consider the need for a strategic shift from treatment to prevention and removing the excess costs of health inequalities as the key direction of the Department and the Executive. The DFP paper is yet another accountancy-driven exercise that diminishes the quantum of care and compromises health workers' and patients' safety.

In respect of capital reductions, the test is whether there will be further delays to the hospital

in Omagh, the children and women's hospital on the Royal Victoria Hospital site and phase B of the Ulster Hospital.

It is time to make up our minds about the kind of society that we want to live in. At Hillsborough, the talks focus on another crisis in policing and parading. However, the right to health, housing, education and jobs was dismissed late last year by the Secretary of State, who rejected all our proposals for the bill of rights. That was done without a word from the Committee, political parties or the Executive.

If other countries can make those connections with their health service, why can we not?

Mr Kevin McAdam (Unite):

Mindful of comments made when last I attended the Committee, I have brought copies of our submission. I have not completed it because I am still waiting for details from the Department.

My colleague has dealt with the Health Service on a global scale; I would like to focus on the effect of the changes and cuts on staff.

The union continues to express concerns about the ongoing underfunding of healthcare in Northern Ireland. Since 2008-09, there has been a year-on-year reduction in the budgets of trusts, and a further reduction is expected in April 2010. That continuous reduction is affecting services, and, although it is not meant to affect service delivery, it can do little else.

The means that trusts employ to make efficiency savings include not filling posts, delaying recruitment, reducing spending on goods and services and delaying the introduction of new services. That has had a negative impact on staff in those organisations, as they have been expected to cope with considerable upheaval following the review of public administration, the comprehensive spending review and the introduction of Agenda for Change, which is a new system of terms and conditions. The new system has taken an inordinate time to implement due to its complexities and the lack of resources for delivering it.

Staff in many trusts are being asked to cover vacancies by working longer hours and undertaking tasks that they would not be expected to do and for which they may not have been trained. That puts the service under pressure and increases the risk of error dramatically.

There are many examples of the Health Service recognising the need for improvement and development. However, such improvements are being stifled through non-implementation, not least the mental health and learning disabilities proposals in the Bamford review.

Positive examples of savings that have already been achieved include the move to generic medicines by pharmacists, which has saved some £44 million over the past two years. We heard detail of that earlier. Healthcare staff were the first workers to be subject to the review of public administration and have demonstrated immense commitment to the changes, sometimes with little or no choice. Healthcare staff have seen management restructuring, loss of managers and a reduction of managers with clinical responsibility; they have been asked and expected to take on lesser roles with ultimate pay reductions and still been expected to deliver an increasing service; and they have been pushed to the edge and are now being asked to deliver even more with less. Staff have been delivering savings and working better, but they cannot continue to be squeezed. The jewel in the crown of the Health Service is its staff, and it now appears that they are expected to pay for the cuts that are being imposed by the Assembly.

I have not singled out any group of staff in my presentation, as all sections of the Health Service have contributed to the savings, managed changes and suffered from the effects of pressures. Staff are entitled to be treated decently in their work, which seems to be the least-considered point in all that has happened in the RPA, CSR and the latest proposals.

A further £113 million reduction in the budget will simply lead to a breakdown in service. The Health Service is at crisis point as many parts of it struggle to reach their year-end savings from CSR. Expecting further savings will mean further pressures on staff, further increases in waiting times and the deferment of necessary service developments. None of that takes account of the impending restrictions on public-service delivery, which appear inevitable. Yet again, staff will be at the forefront of any cuts.

Politicians will have to be honest with their electorate that they are the people who are demanding that services be reduced, that waiting times be increased and that life-saving drugs are available but are too costly.

The proposed cuts will affect service delivery by increasing waiting times, decreasing staff

morale and increasing the risk to patients and the public in the delivery of care. That will affect the community across Northern Ireland, with the least well off and those most in need suffering most.

The Health Service in Northern Ireland is expanding and needs the necessary funding to make the required improvements to a service that has, sadly, been under-resourced for more than 30 years. Much effort has been put into developing clinical excellence in several areas, and we have some world-leading facilities of which we can all be proud. However, we have a great deal more to do to bring our healthcare up to a standard that we know we can deliver.

The Executive need to take a critical look at how health is delivered in Northern Ireland and, although some outside the sector see cutting non-clinical roles to a bare minimum as an easy way of saving money, they have to realise that the organisations that deliver the service are large and complex and must be managed effectively to deliver for their clients. Responsibility for not delivering the service that the public expects lies with the funders. Staff have been involved in implementing change and have had to adjust to different working patterns and practices in new organisations; they are showing commitment.

It is incumbent on the holders of the purse strings to fund the work that needs to be done. The trades unions believe that the health budget should be protected from cuts and funded to provide for the people of Northern Ireland.

The Acting Chairperson:

I thank Kevin and Patricia for their presentations.

I have two points to make, although they may have been answered in your presentation. First, did you learn anything from the Minister's presentation?

Ms McKeown:

We came in halfway through the Minister's presentation; therefore, we did not hear what the Department had to say about the equality impact assessment. It was mentioned on the way out. We want to see it in more detail, and we want it to be fully compliant with the guidance. It is an essential task at this stage.

The Acting Chairperson:

The Committee is also trying to get more information, as it is important that we get all the information available.

Ms McKeown:

May I say one more thing about what we heard? We heard your exchange on parity pay.

The Acting Chairperson:

That was my next point.

Ms McKeown:

That is profoundly disturbing. I have been in this job for 30 years. When I first started, home helps in the Belfast area were paid about 70 pence an hour; home helps west of the Bann were paid 30 pence less, and their pay was three times lower than their counterparts in England, Scotland and Wales. For us, regional pay means low and unequal pay. It has taken us 50 years to get equal pay into the NHS, whose workforce is more than 82% female. It has taken from the inception of the NHS to date, through the Agenda for Change process, to get there.

We will resist strongly any attempt to introduce regional pay. If anybody wants to switch the parity link with Britain, the only other place where we would look would be the Republic of Ireland, where they are paid considerably more than we are.

The Acting Chairperson:

When you talk about parity pay, do not assume that you are talking about low-paid workers.

Ms McKeown:

Unfortunately, the system encompasses everybody else.

The Acting Chairperson:

I know what you are saying.

Ms McKeown:

Believe you me, we have been highly critical of merit pay; we have been highly critical of the contracts that were recently struck between the UK Government and doctors, including GPs,

which we believe restrict the service unnecessarily. However, that does not mean that the answer is to break the parity pay link.

The Acting Chairperson:

It is about teasing out information.

Mr McDevitt:

For clarity, as Ms McKeown may not have heard the early part of the exchange, the question was about the merit pay system. It is fair to say that it was transformed by the Minister into a wider debate about parity. We should have all the information, but it was not the mood of the Committee or any member to open the debate beyond the merit principle.

Ms McKeown:

Thank you; that is music to our ears.

Mr McDevitt:

Do you consider the merit principle to be equitable? I agree that equality has to be at the heart of not just how we provide and design the provision of health services, but also how we reward the people who participate in them.

Ms McKeown:

For the past 30 years we have been critical of merit pay, as there are questions about the lack of transparency and whether it is top-sliced from the main budget. We do not say that we do not need some incentive to keep the top level of professionals here — we have some superb clinicians that we would not want to see go elsewhere because the money was better. We understand that. However, it must be open and transparent and everybody needs to understand why they get the money. I hope that they get it because they are doing more and because the patients in that person's area of expertise demonstrate that there is a difference in the health inequalities and throughput.

In the old days, people had to do more to earn a bonus. Bonuses have been cast aside, and I am very happy about that. One did not get a bonus just for turning up.

Mr McAdam:

One must also look at the advantages of the national scheme. At its best, it is measured by looking at experience where incentives were applied to some groups of staff to keep them here and to stop them going to the Republic of Ireland. Pharmacists are a good example. It was a very unbalanced method, whereas the current scheme works well and equitably across the UK.

Mr McDevitt:

I do not want to get caught up on pay issues because, as a member of a Labour party, it is complex; I do not want the conversation to get hijacked. Given the grades of the people that you both represent, and given that, as Mr McAdam suggested, they will bear the brunt of the savings required, do you feel equally comfortable now, on reflexion, with your earlier remark that everyone, in every grade in the system, has borne their fair share of the burden to achieve the cost efficiencies that we will all need to see come out of the system in order to preserve the standards and provide the service that we want? Can you say that about the individuals who are sitting on the seats that you occupy right now? For example, can you say that we should not have anything on the agenda about senior salary capping for the foreseeable future? Should we rule that policy out; or do we need to reflect on it if we want to protect the service as we know it?

Ms McKeown:

In tough times, one looks at everything. Frankly, however, that is the wrong place to start. We have an historically underfunded Health Service. God knows, at one stage I tried to count the number of Health Ministers that I had been through in 30 years. Almost every direct rule Minister raided the health, education and housing budgets, with the excuse that the money was going into security. Oddly enough, they did not return any of it after the ceasefires. That is one of the reasons for the huge gaps in our funding for acute mental and children's health services. Jim Prior was the only person I ever remember doing a U-turn, and that was a long time ago.

However, every study carried out on our healthcare funding during the past 20 years, whether Government led, public-body funded, or independent, has demonstrated the extent of the gaps. The previous devolved Government carried out needs and effectiveness surveys that showed that the gap in funding was even bigger than we had thought. It is a very serious issue.

We could decide to spend more on our Health Service; we could decide to do things differently, such as Wales has done; or we could learn lessons from the countries in western and

northern Europe. If we were serious about developing the economic base, we would pay more attention to that. At this stage, we are looking at the need not only to do the equality impact assessments but to do the socioeconomic impact assessments on local communities.

I am genuinely concerned about the campaign that is being run in the city of Armagh. As we reorganise the public service and as we are hit with cuts of this immensity and the jobs are either transferred elsewhere for operational reasons or cut because the money is not there, you will see some seriously deserted local economies. We have to take that into consideration too because, ere long, that is where health inequalities start to grow again. I do not think that that work has been done.

Mr McCallister:

Thank you for your presentation. The equality impact assessment is vital. We went over some of this with the Minister, and I agree wholeheartedly. There is cause for concern: what will happen to service developments or capital spend? I made it clear that I support parity pay.

You mentioned bureaucracy. I take it that you are broadening that out into some of the new structures. The administration costs in the trusts are about 4%, which is surprisingly low. Can you elaborate on the Equality Commission's guidance and why you do not think that it is an efficient or desirable model? My thinking is that it might have added an element of competition to get some services from commissioning groups.

Ms McKeown:

One of the problems with our Health Service is that a significant part of it — the five super-trusts — was put in place by direct rule Ministers. The sixth trust — the Ambulance Service — is in much the same state as it was.

We had signed-up to an earlier RPA model of healthcare delivery, as had most of civic society. That model flowed from the work of Maurice Hayes and his committee and did not require the commissioner/provider split. With that model, we would have had an effective regional health authority, and everybody else would have come under the collective banner of the Health Service to deliver healthcare, but they would also have had an input into healthcare planning, for example. At present, the five super-trusts do their own healthcare planning — even though no one asked them to — and make their own decisions. The Regional Health and Social

Care Board came into existence two years late, so it has not yet found its feet. We also have the local commissioning bodies.

The present model will not work, because there are unnecessary layers that could be removed. The cost of removing those layers should be established, and some real thinking needs to be done on whether the system is required in its current format. What was wrong with the original RPA model? The trouble is that the Hain Administration got its hands on it and changed it at the last minute. The original model was approved by our politicians, civic society and by clinicians.

If we want to create a healthcare system based on a public health model that will emphasise well-being and prevention as well as being able to reduce expenditure, we need a far better method. Recent events have shown that there is a great deal of tension between the trusts, the regional health authority, and the Department of Health, Social Services and Public Safety, because everybody is holding on to their own turf. You do not get the true picture when everybody is guarding their own turf; you will get the true picture when everybody is part of a collective healthcare delivery system.

Mr McAdam:

One of the difficulties with the implementation of the review of public administration was that, two years in, the comprehensive spending review came along. When cuts in services were being made and the delivery of services was being reorganised, an additional 3% cut was imposed. That caused confusion, but it also led to cuts being made in the wrong places, because trusts had not bedded down into their new organisations and their new working systems; people walked into new posts and immediately faced cuts to their budgets. That has had a big impact on the service.

Mr McCallister:

Some might argue that a super-authority would have been very bureaucratic, but it would depend on how it was tied in with other structures.

Will healthcare inequalities increase dramatically? Since we are starting more than £600 million behind the rest of the UK, will the proposed spending plans not have a dramatic impact on health inequality?

Ms McKeown:

It will be worse than our worst experience so far — the Thatcher years — when there were dramatic cuts to the health budget that unfairly and disproportionately affected cleaners, caterers and home-help services.

The Acting Chairperson:

I am sorry to interrupt you, Patricia, but someone's mobile phone — not mine this time — is interfering with the Hansard recording. I ask everyone to double-check to ensure that their mobile phones are off. Thank you.

Ms McKeown:

This time round, we have a clearer picture of the size of health inequalities; we know how quickly need is developing, so we fear that the proposed cuts will have a profound effect on direct healthcare delivery. There has been a great deal of goodwill and free working in our system for nearly 50 years, but that cannot be sustained.

I have never before seen fairly senior social services managers, many of whom are members of my union, reduced to tears. That is a new development that is caused by the strain and stress of taking work home and trying to figure out how to deliver services. I have never had so many nurses tell me that they have taken time off with breakdowns or near breakdowns. That is another new development in the Health Service. It might have happened in other places, but it is new to us.

That is extremely disturbing and must go into the pot. The union has carried out some exercises to measure the mental health of health workers. We have been able to turn some bad results around by introducing new practices at a local level. However, the extent of health workers' serious mental health problems, which are caused by the situation that they are in, is highly disturbing.

Mrs McGill:

You are both welcome. In response to John McCallister's question, you touched on issue of commissioning and the provider. My question has probably been answered somewhere, but I have not seen it. Is it too late to change that system now? I ask that question without prejudice.

Ms McKeown:

I do not think that it is too late.

Mrs McGill:

If it is not too late to change it, I would like to see a concise and bullet-pointed document — it may already exist — in which one side of the page should outline the current position and why it is not working, and the other side should outline what you think will work. It should be a focused summary.

Ms McKeown:

I would be happy to provide that. I am not entirely sure whether we have already submitted it to the Committee. However, we certainly produced it speedily when the Assembly was restored because we had hoped that there was still a window of opportunity to turn the situation around. At that stage, the legislation was in place and the new trusts were being founded. It is never too late. The Health Service structures have been interfered with many times in the past 50 years. For once, we would like to see reorganisation that is for the good of the people and the service.

Mrs McGill:

Would change require legislation? What must be put in place in the system to change it?

Ms McKeown:

It would require no more legislation than the exercise that we went through recently. New legislation was required to set up the new trusts, the new board and the Public Health Agency. However, that was passed fairly speedily.

Mrs McGill:

I am only asking whether, according to your thought-out position, legislation would be required to change the current arrangements. I am only trying to get my head around it.

Ms McKeown:

It would be necessary to amend the legislation that established the existing arrangements. That is a fairly technical exercise; that is how the previous changes and the changes before that were made.

Mrs McGill:

As I said, I ask without prejudice. I am only trying to inform myself about your thinking on the matter.

In response to Mr McDevitt's question, you referred to the situation — particularly the payment of staff — in the South of Ireland. Is the health service in the South of Ireland a good example of how our Health Service should work?

Ms McKeown:

I would not touch it with a bargepole. I attended a meeting in Dublin last Wednesday. An historic milestone in healthcare delivery was reached on that day — 500 patients were on trolleys. That is the highest number in the history of the health service in the Republic; it was a day of shame. I never want to see our Health Service in that position.

Mrs McGill:

You referred to the Omagh hospital in you paper. Have you heard something new, and is it your view that that project will be delayed further? As somebody from west Tyrone, I am keen to know.

Ms McKeown:

It is not that we have heard something. We are saying that three major capital developments are now waiting. Millions of pounds cannot be taken out of the system without that impacting throughout the system. It is not clear what the impact on infrastructure spend will be. However, somebody needs to find that out and say whether we are in for a very long wait.

Mrs McGill:

Point 7a of your written submission states:

"Every health service post deleted reduces our capacity to deliver healthcare in the face of under funding an inequality."

Would you elaborate on that please?

Ms McKeown:

Straightforwardly, we are —

Mrs McGill:

You refer to “every” post.

Ms McKeown:

For years, no matter who was in Government, I have heard it said that, whatever happens to the Health Service, front line services will be protected. However, I have never heard anyone define front line services. Therefore, we have our own definition, and, in our view, a front line service comprises everybody in the healthcare team who treats patients, who looks after residents or who makes sure that the public health model is in place. Every job that is cut will lengthen the queue or remove that service altogether.

Some of the key community healthcare services are down to one individual who is trained and qualified to deliver that service. It is not just a question of talking about budget cuts in big numbers and percentages. That has to be translated into what it really means for jobs.

At the moment, we are in danger of seeing whole tranches of the Health Service dependent on casual labour by agency workers. That is not my idea of a healthcare team, but, as we speak, that is in place. It is referred to as “vacancy control”, and it happens because more cuts are coming, and people do not want to fill jobs, as the salaries and wages budgets will increase. Things cannot go on like that, because that is having an impact on care.

Mrs McGill:

Are you saying that there can be absolutely no reduction in staffing anywhere across the Health Service?

Ms McKeown:

I did not say that.

Mrs McGill:

I am asking you if that is what you mean.

Ms McKeown:

I go back to what I said about the commissioner/provider split. At the minute, we have a Health Service system that could be constructed in a more effective way. In our view, the system is not

right and would be more effective without the tiers. If the system did not have tiers, savings could be made, and there are other parts of the system in which major savings could be made.

It is true that the trusts are trying to find smarter ways of doing things following the big mergers, which, for example, in Belfast, resulted in six already big trusts coming together as one giant trust. However, there is a question around whether bigger is better and more efficient, or, as I believe, whether the localised delivery of healthcare is the right way to go. Perhaps that is the most efficient way to deliver in the system. I do not think that those areas have been properly evaluated or tested as better models for delivery.

The Acting Chairperson:

I am conscious that we have another meeting at 12.45 pm.

One reason why we wanted union representatives to give evidence to the Committee was so that we could get a holistic picture of what is going on. It is unfortunate that we are still waiting and trying to tease out information from officials. I do not see the issue ending today, as a number of Committee members are not here, including the Chairperson, whose wife has been taken ill. The issue is about how we build a relationship, and, as I said, we cannot make any decisions today. However, we have heard the presentation from the Minister and his team. Have you had any recent discussions with him or the Department following the DFP statement?

Ms McKeown:

We have not had an opportunity since the DFP statement was made. We had serious discussion with the Minister about promoting equality of opportunity throughout the system, and I had a very good response from him about that. However, we now need a system response.

The Acting Chairperson:

Have you had any discussions with other Departments about a proactive approach to health? The Minister, in even his presentation, said that health, education and housing were three of the cornerstones, along with any other Departments, of Investing for Health.

Ms McKeown:

We have not had discussion with the Departments directly. We have had discussion at the level of First Minister and deputy First Minister at three or four meetings in the past 12 months, while

wearing our Irish Congress of Trade Unions hats. We are keen to emphasis that if everyone's responsibility for better healthcare were to be lined up, it would not all fall on the shoulders of the Department of Health, Social Services and Public Safety.

We told the Committee before that free nutritional school meals for all children makes a big difference. Public housing makes a big difference. There are all sorts of areas of social development in which DEL could be involved, for example, training, retraining and job creation. Those all add up to a healthier population that will not require the billions of pounds that are being spent on areas such as coronary care and diabetes treatment, or the enormous amount of money that is pumped into end-of-life treatment. It is possible; other countries are doing that. There are really good models that show how to make a population healthier. It is a combined effort by government and does not rest on the shoulders of one service.

The Acting Chairperson:

The Committee is due to be briefed by Cooperation and Working Together. Is this island big enough for two healthcare systems?

Ms McKeown:

It is a tiny island. We get money from elsewhere for our healthcare system. There is a healthcare system in the South that is not one that we would want to see. We are working with the two health services on cross-border co-operation from the union point of view. Co-operation could achieve efficiencies and lift standards. At the end of the day, however, I still want to live in a system that has a taxation-funded healthcare system that is free at the point of need for all citizens and not one where the people have to pay.

Mr McAdam:

With regard to co-operation with other Departments, we have sought to expand our partnership forum, which comprises the Health Department and trade unions, to include representatives from other Departments to look at the healthcare problem from a holistic point of view. We are continuing with that.

The Acting Chairperson:

The Committee has been looking at this matter. Its findings are similar to those of its obesity report. It is not just a Health Department issue; other Departments need to be involved.

Ms McKeown:

Yes, very much so.

The Acting Chairperson:

On behalf of the Committee, I thank you for providing the paperwork and for coming here today. Again, I apologise for the absence of the Chairperson and Deputy Chairperson. That was beyond their control. If the Committee gets any more information, I am sure that it will be on the Assembly's website, where you might be able to access it. Thank you.