COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Draft Budget 2011–15: Professor Ciaran O'Neill

18 January 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Mickey Brady
Mr Pól Callaghan
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr Paul Girvan
Mr John McCallister
Ms Sue Ramsey

Witness:
Professor Ciaran O'Neill) NUI Galway

The Chairperson (Mr Wells):
I welcome Professor O'Neill and invite him to make a brief presentation, after which members will ask questions. We will limit the session to 45 minutes if possible. Is this the first time that you have appeared before the Committee for Health, Social Services and Public Safety?

Professor Ciaran O'Neill (NUI Galway):
No; I have been here before.

The Chairperson:
Therefore, you know the routine. I hope that the session will not be too difficult. You set the scene, and then we will ask questions. Thank you for your time.

Professor C O'Neill:
Thank you for the opportunity to speak to you today. I prepared a brief paper so that you have something to look at while I am speaking rather than looking at me. I will go through the document briefly, but rather than simply reading it out to you, I will speak around it. You will have an opportunity to ask questions that you feel are appropriate.

As others have commented, it is regrettable that the draft budget document came late in the day. That constrained my opportunities to review it and to prepare some comments. It is not as detailed as I would have desired, but, that said, I will make some preliminary comments and remark on certain areas on which I have focused.

From my perspective, I thought that it would be useful to refresh my mind about the role of health and social services. I have framed that so that I can get a better understanding of how to interpret the use of resources that were being allocated to them. My understanding of the role of health and social services is to ensure that there is equal access through health and social care, based on need rather than on ability to pay. That gives me a way of viewing whether resources are being used in accordance with the pursuance of that goal. In itself, the goal has efficiency and equity considerations. A narrow interpretation of the goal simply based on efficiency might make it difficult to understand some other funding requests that are being made. Professor Normand or I could refer to numerous examples regarding the equity–efficiency trade-off, but it is useful to bear in mind that there are issues around equity and efficiency in the use of healthcare resources. It appeared in the draft budget document, so I thought that it was useful to restate that, because, on occasion, there are references to maintaining employment or incomes or addressing issues of poverty. Although health and social care has a role in relation to those issues, the responsibility for addressing poverty or the creation of employment rests better with other Departments than with that of health and social services.

In the paper, I also refer to staff morale in health and social services. Again, it is incumbent on the Department of Health, Social Services and Public Safety (DHSSPS) to ensure that morale

is maintained and does not get in the way of the delivery of quality health and social care services. The role of morale in productivity needs to be addressed not simply through positive incentives, which are afforded through pay and terms and conditions, but through the need to ensure that staff are held to account on their performance and the delivery of health and social care. I refer to that solely because it appears in the draft budget document.

After that rather long preamble, I will now consider particular aspects of the draft budget that I have identified and singled out for comment, based on the contribution that they make to overall spend. I have gathered my remarks under different headings, the first of which is the briefing document. In the briefing document, which was delivered to you last Wednesday, you are presented with a series of tables with accompanying discussions. The tables identify the available budget, the desired budget, and the difference between the two. The document also identifies options on how to bridge the gap between the two. Some of those are expressed as job losses or, for example, the inability to provide access to high-cost drugs for some people.

My understanding is that at least some of the figures have been prepared by another agency, the Health and Social Care Board. If the Department can provide assurances about the underlying calculations, that would give you, as the scrutiny Committee, greater assurance that they are accurate. It is important that you are assured of the accuracy of figures that are presented to you.

As far as I can determine, absent from some of the options that are identified — this comes out in the detailed draft budget proposal that was submitted to the Department of Finance and Personnel (DFP) — is how efficiency gains could be pursued in the DHSSPS or its agencies. For example, there is no discussion about whether efficiencies could be achieved through more imaginative commissioning arrangements or through bearing down on aspects of cost that it may be possible to address. I would have thought that those were areas in which the Department could perhaps identify potential savings, which may afford it opportunities to address the difference between the allocated budget and the desired budget. I imagine that you may wish to come back to those issues. I will leave them for the time being and move on.

I identified areas in the draft budget and in the briefing document that I believe warrant consideration. I do not have all of them in front of me. I have an incomplete document from my own notes. Some of my comments will be from memory rather than from detailed notes. From recollection, I identified three areas: demographic change; pay; and residual demand. With

regard to demographic change, it is envisaged that the ageing population of Northern Ireland will result in increased demands on the health and social care system. There is a request for additional funding to make provision for those additional needs.

In my paper, I refer to two areas of ongoing debate in health economics. One relates to the concept of morbidity compression and whether, as the population ages, we will require the same level of resource that we required in the past for an older population or whether, because people are ageing in a healthier way than would have been the case in the past, we will not need the same level of resource. That debate is not resolved. It is ongoing, and people have different perspectives on it. There is an opportunity to explore that issue in Northern Ireland and to find out whether we are likely to experience morbidity compression and, therefore, will not require the same level of resource or the same manner of delivering that resource as was the case in the past.

The second issue is the level of self-reported health evident among older people in Northern Ireland and a comparison between that and that which has been reported in other jurisdictions, particularly in the Republic of Ireland. Comparisons between Northern Ireland and the Republic of Ireland demonstrate that people in Northern Ireland say that they have higher levels of need. They report poorer self-reported health than is the case in the Republic of Ireland when various controls have been put in place. There is a relationship between self-reported health and utilisation, but the nature of the relationship needs to be explored. I do not think that there is necessarily evidence of demand inducement, but there may be potential for better demand management than has perhaps been used in the past. I have provided some references on that issue.

In the draft budget document, there are different examples under which additional funding is requested in relation to pay and the overall wage bill. There is reference to a bonus for staff who are paid under £21,000 and to pay progression along salary scales. There are other examples, such as Agenda for Change. I do not know about the bonus for people who earn under £21,000. There are supporting spreadsheets, but even if I had been given those spreadsheets, I would not have had time to go through them. Therefore, I do not know whether the numbers who are eligible for that bonus are underestimated or overestimated. There is a reference to 35,000 whole-time equivalents, but given that many health and social care workers may work part-time, more than 35,000 people may be eligible for that payment, or it may be the case that there may be fewer than 35,000.

Progression along salary scales is also an issue. Individuals are placed on salary scales, and reference is made to an expectation that they will progress along those salary scales because of contractual obligations. Although the Department may have sought legal advice, that could change, depending on the way in which the question that was offered to the Departmental Solicitor's Office was actually framed. I do not know how the question was framed, but the advice received may change in light of a different framing of the question. However, putting that to one side, as a scrutiny Committee, you may wish to satisfy yourselves that progression along the salary scales is being interpreted consistently. For instance, if an individual progresses along a scale but moves on to a different band, is that being considered simply as progression or as promotion? That may have implications for an increase in the wages bill.

The final issue relates to residual demand. As I interpret it, residual demand is making provision for improvements in technology or in the quality of service that will be delivered by health and social care services. It is prudent to make such provisions, given the way in which health and social expectations and technologies have advanced over time. The figure that is quoted is a 2·5% provision, based on a figure quoted in 2010-11 of approximately £4·3 billion. That is compounded to allow for and to make provision for growth thereon. Although provision can be made for those additional expenditures, it is important to ensure that any allocations are being used in a fashion that delivers cost-effective care rather than simply improvements in service or in the ability to deliver on individuals' expectations. I would question whether the mechanisms that are in place can do that and can demonstrate that that is happening.

Similarly, when new technologies emerge and are being adopted, is it the case that evidence can be provided to show that currently funded technologies are being decommissioned, or is it a case of the new plus the old? The expectation may have simply been for the new.

That concludes my remarks; I think that I stuck to 15 minutes, so I have done that if nothing else.

The Chairperson:

Thank you, Professor O'Neill, for the benefit of your expert evidence. I detect, from your accent —

Professor C O'Neill:

Belfast.

The Chairperson:

You have much experience of the Northern Ireland situation as well as of that in the Republic. I will ask you to draw on that. We met members of the Dáil's Health Committee and discussed issues of mutual concern. Can you make any comparison between the levels of funding in the Irish Republic and here? Do you perceive us to be underfunded or over-funded? Are we getting expenditure right, or are there examples from which we can learn from your experience in Dublin and further afield?

Professor C O'Neill:

I do not have the figures to hand, so I will not quote them. However, I will say that there are two very different healthcare systems, North and South. In the South, there is a public–private delivery system as well as a public–private finance system. I do not think that that system delivers or finances healthcare as efficiently or equitably as is the case in the North. I do not have the figures to hand for the levels of spend per person. I do know that utilisation of service differs between the two jurisdictions. However, that needs to be delved into to examine who is utilising what, rather than simply looking at the headline figures. If, for example, individuals are eligible for public services in the South — general medical services (GMS) type patients — their utilisation of services is higher than that of their Northern counterpart. However, for people in the South who have to pay for access to services, their utilisation tends to be less than that of their Northern counterpart, even with control for aspects of need. I can provide references for that.

The Chairperson:

I suppose if people are paying for medical care, they make jolly certain that they are ill before presenting themselves for scrutiny or treatment.

Professor C O'Neill:

I think that people respond to incentives and having to co-pay may result their not accessing services as readily as may be the case if they did not have to pay for access to services.

The Chairperson:

You mentioned some of figures that we have been examining — the "inescapables" or

"unavoidables" as they are called — which are included in a table from the Department. Residual demand comes out at £462 million, which is a colossal proportion of the budget. Do you suspect that there is any element of gold-plating in that? It strikes me as such a huge figure. Cutting that amount by one third to £315 million would go a long way to meeting the Department's perceived problems. Is there any indication in the material that you have seen as to what level of figure that is? Is it the ultimate level or what we could do if we had an unlimited sum of money? Alternatively, do you think that, no matter what happens, an element of that will have to be spent because it is absolutely essential?

Professor C O'Neill:
Health technology advances very quickly. The goal of for-profit companies — pharmaceutical companies — is to develop new technologies continually, because their existence depends on that. In turn, those companies will respond to incentives. Therefore, if a ready market exists for their technologies, they will continue to develop new technologies. I am dredging something up from memory, but it has been said that it is like a Sisyphean syndrome, whereby we are on a constant treadmill of technological developments, which we fund, which results in further technological developments, which we also fund, and that goes on and on. That is not to say that that is a bad thing. Technologies that afford us a better-quality or longer life are good provided they are worth the money.

I am aware that pharmaceutical and medical device technology companies are working on a range of new technologies, which will be adopted into the service if the funds are available. As regards pharmaceuticals, it may be worth your while speaking to organisations such as the National Centre for Pharmcoeconomics in Dublin, because it will be able to furnish you with details about growth in pharmaceutical expenditures in the Republic of Ireland and to separate that out into elements of high-cost drugs, low-cost drugs and even what are referred to as "orphan" drugs.

The Chairperson:
One of the great dilemmas that we face is that drugs such as Lucentis and anti-TNFs are expensive but produce outstanding results for an individual's quality of life. If someone takes Lucentis, basically, he or she will not go blind. That is a pretty black-and-white situation. Once that advancement is made, it is difficult to say that we should not adopt it and build it into the figures. Equally, however, I am sure that there are drugs and treatments that have a more

peripheral impact on a person's health. We are faced with an enormous figure but have been given very little explanation as to exactly what that entails. Given your expertise, would you have expected much greater detail about where that figure came from?

Professor C O'Neill:
The short answer is that if I were controlling the budget, I would like to see detail, if not to find out exactly what the money will be used for, given that you are looking into the future for new technologies that might emerge, at least to seek assurances that a new technology, if one were adopted, would be closely scrutinised to ensure that it was cost-effective. However, bearing in mind that the definition of cost is an opportunity cost, consideration would need to be given to what must be given up to fund that new technology. Nevertheless, there may be alternatives that would afford the Health Service an opportunity to find efficiencies.

It may be the case that technologies are not being used to the greatest effect, and I will give you some examples. First, people can be given a new drug or, indeed, an existing drug, but if they do not adhere to it, what is the point? A cost is being incurred without their getting any benefit. If they are not taking the drug or not taking it in an appropriate fashion, that creates a difficulty. There is evidence that that happens.

Secondly, my experience of pharmaceutical companies is that that they are open to risk sharing, but I do not know whether that happens here. The adoption of new technologies can be risk shared in the sense that a technology would be paid for only if it demonstrably worked and would not be bought if it did not work. My experience is that pharmaceutical companies are open to those arrangements. I need to think of a third example.

The Chairperson:
If you remember another example, let us know.

You also raised the issue of incremental pay progression. There is a pay freeze in the first two years for anyone who earns less than £21,000 a year. However, throughout that process, increments continue to be accrued to individual pay spines. Those may be called increments, but technically they are pay rises. A delegation of health workers visited me just before this session. If people go into a certain job, they go up one point on the scale in year one, two points in year two, and so on, until they get to the top of that spinal column, after which they would move on to

another one. We have yet to identify whether that is mandatory and whether we cannot, therefore, get out of it. Drawing from your experience in the Irish Republic, which is facing equal problems in funding its health service, has a decision been made on the issue of funding staff? Have increments stopped as well as pay rises?

Professor C O'Neill:

The short answer to that is that I do not know. However, I do know that, where there is ambiguity, it will be exploited. If something is seen as a promotion, it needs to be nailed down as a promotion, and the distinction between promotion and progression needs to be very clear.

The Chairperson:

The increment system in the Health Service seems to be that, provided people do not blot their copy book in year one, they get an increment. It is not based on any merit other than the fact that people have done their job satisfactorily, but they do not have to be outstanding; it just happens.

Someone still has a mobile phone turned on, and the broadcasting people are doing their nut. It is interfering with any words of wisdom from Professor O'Neill or me; there are probably more words of wisdom from that end of the table than from this one. They are not called "crackberries" for no reason, and people do get addicted to them. I suspect that a few press releases have been issued from them already this afternoon, even in the first half-hour of this meeting. Please avoid the temptation.

The incremental increase is taken as read, which is effectively a pay rise, yet the Department says that there will be no pay rises in the first two years for people earning less than £21,000 a year. The figure is quite substantial — £78 million. I wonder whether, on this issue, we just do not go there, or should we be looking at it for potential savings? We are being told that, in the worst-case scenario, there will be 4,000 job losses. That is what the Minister is saying, although some of us have our doubts. There would easily be enough in that pocket to ensure that there are no job losses at all.

Professor C O'Neill:

We could view that from two different perspectives. One could say that there is a contractual obligation to meet the expectation for increments and that it would be unjust not to meet that expectation. On the other hand, if people are sitting at the top of their scale and not allowed an

increment, moving on to the next band is a promotion and not simply a progression. It could be said that those people are being disadvantaged because of being very good at their job in the past, or simply being there for a long time and having benefited from that.

As I said, I do not know the way in which the question was framed to the Departmental Solicitor's Office, but if the question were framed differently, it may be the case that the Departmental Solicitor's Office would offer different advice. In the context of a budgetary crisis, when all individuals are subject to the same change, I do not know whether their opinion would differ, and, more importantly, I do not know whether the opinion of an industrial tribunal would differ. I am not a lawyer, so I do not know.

The Chairperson:
Perhaps there has been a legal case, or an industrial tribunal ruling that there is no flexibility; we do not know.

Professor C O'Neill:
An industrial tribunal would rule on the merits of the case presented to it. As I understand it, the way in which industrial tribunals work is very specific, so I do not know whether we could generalise from that and apply it to other situations.

Mr Easton:
Do you agree that the level of detail that the Department and the Minister has given to us so far is too poor for the Committee to make any recommendations? It was not demonstrated to me where the 4,000 job losses would come from and why. I believe that a game is being played to try to maximise pressure on the Budget and get more in a final settlement. Do you agree that the absence of detail on the 4,000 positions makes it extremely difficult for us to make a judgement? Do you also agree that the lack of issues and information on efficiencies shows that the Department does not want to go down the efficiency route as much as it should?

The Chairperson:
Professor O'Neill, we would not expect you to comment on the internal political situation between the Committee and the Minister.

Mr Easton:

You can if you want to.

The Chairperson:

You will probably want to avoid that, but you can answer the more open question on the lack of an obvious concentration on efficiencies.

Professor C O'Neill:

I imagine that the work is ongoing rather than complete, so there will be an opportunity to fill out the detail and to scrutinise how funds will be used in the future. Again, there are two ways of looking at presenting a range of options if the budget allocated does not match what is desired. The provision of a range of options could be seen as an opportunity to engage people in a debate about implications, or it could be viewed as having created uncertainty about implications and the way in which those are reported might cause difficulties. I do not know whether or not I am agreeing with you, but I am commenting on the question that you asked me.

When I read the draft budget document, I was struck by several references to there being no scope for efficiencies. I do not think that I accept the fact that there is no scope for efficiencies in the Health Service. It is not that the Health Service is inefficient, but I simply do not accept that it is perfect. I think that there are ways in which resources could perhaps be used to greater effect.

Mr Easton:

What about the 4,000 job losses?

Professor C O'Neill:

I do not know how the figures were generated, so I am loath to comment on that.

The Chairperson:

I should have called the Deputy Chairperson to ask questions immediately after me. I am sorry about that.

Mrs M O'Neill:

Thank you, Ciaran; you are very welcome to the Committee. One of the biggest jobs for the

Committee is to try to scrutinise the draft budget. When there is an absence of detail, we find it hard to support the Minister's call for additional funding and an increased budget. When the Minister was in Committee last week, he may as well have done the calculations on the back of an envelope, because we could not get details on how a figure of 4,000 job losses was arrived at.

The Chairperson picked up on a few broad areas, and I want to pick up on the issue of demographic change. Professor Normand and you refer to that issue in your papers. Given that it is quite a substantial bid by the Department —

The Chairperson:
I am going to have to stop you; I am sorry about this. Somebody still has a phone switched on, and we will have no Hansard report of the entire hearing if that continues. It must be somebody who is extremely popular, and the requests from his or her constituency are pouring in. Barring frisking people and taking their mobiles off them at the door, I do not know what we can do.

Mrs M O'Neill:
It could also be somebody in the Public Gallery.

The Chairperson:
It could, I suppose, but it is more likely to be someone who is near a microphone. I hate to be a schoolteacher about this, but what is being asked is very important, and we need to get it on the record. The guy who can invent a machine that stops this happening will make his second million. If it happens again, I do not know what we are going to do. We will have an amnesty for BlackBerries, and you can hand them all in at the door.

Mr Easton:
And iPhones.

The Chairperson:
And iPhones. I am sorry, Michelle.

Mrs M O'Neill:
I was talking about the issue of demographic change. There are substantial bids, year on year. Perhaps Professor Normand and you are suggesting that it is hard to get to the detail. The

Department states that we have an ageing population, which we accept, but we cannot see how the costs identified with that work out in practice. Will you comment a little more on how you feel that the Department's bids relate to the actual need that will be presented because of our ageing population?

Professor C O'Neill:

I refer to cross-border work that was carried out by — I hope that I will get her name correct — Hannah McGee and others, such as Richard Layte from the Economic and Social Research Institute (ESRI). I believe that Hannah McGee is from the Royal College of Surgeons in Ireland (RCSI). Charles can correct me on that. That research compared self-reported health, North and South. It examined why there are such huge differences in what is reported between the two jurisdictions. It is not clear why that is the case. It could be hypothesised that if services are provided, people will use those services, and they may use them at a lower threshold than is the case in another jurisdiction where resources are more constrained. That comparison was made at the same point in time.

The notion of healthier ageing, which has been floating around in the literature for some 30 years, is that it is not how old, but how close to death, someone is that determines his or her utilisation of health services. I smiled before I said that. The reason why that is important is because work has been done to evidence it. It means that if people can be kept healthy for as long as possible — ultimately, all of us will die and they will too — their consumption of healthcare resource will be less than would otherwise be the case.

My understanding is that conclusions have not yet been drawn. However, the literature seems to suggest that there is evidence that as we age, we have more conditions now compared with what was the case in the past. In some respects, we are equally as unhealthy as we would have been previously. However, those conditions are not as severe as they would have been in the past. Therefore, we are ageing more healthily. There is no reason to believe that that should change during the next four years. Further down the time horizon, it may change as we start to experience the impact of obesity on the population.

However, as I said, the notion of morbidity compression and the relationship between provision and utilisation need to be disentangled and considered with greater care so that you can assure yourselves that the resources that are being requested are necessary and will be used to

good effect. Sometimes, the “woodwork effect” is mentioned: if something is provided, people will appear out of the woodwork to consume it. You want to ensure that that does not happen. Resources should not be used that could be used more effectively elsewhere.

Mrs M O’Neill:

We do not know what the Department has taken into consideration. In the absence of that knowledge, do you think that there is an overestimation of bids? Perhaps it is unfair to ask you that question.

Professor C O’Neill:

It is a legitimate question. However, I cannot answer it without going through the Department’s calculations in detail and having the opportunity to challenge it on them in the same way that I would be challenged on a piece of evidence that I produced; at least, I hope that I would be challenged on it. Evidence actually improves as a result of the to and fro of debate and of being asked whether you have thought of this or that.

Mrs M O’Neill:

Last week, the Department said that year one will obviously be its most challenging and that if it were able to re-profile its budget over the four-year period, it would be able to manage it more efficiently. Do you have an opinion on that?

Professor C O’Neill:

If you are required to make tough decisions, that is what you are required to do. You end up making those tough decisions. If more time is given, a decision may be deferred. That is not to say that being afforded more time will allow greater space to realign services. However, in a budgetary crisis, tough decisions have to be made. We saw that in the Irish Republic, which has experienced pay cuts, increases in pension contributions, and so on.

The Chairperson:

I asked the Minister of Finance and Personnel that question, and he said that every Department wants the same thing: namely, relief in the year one and savings being loaded into year three and year four. All Departments face the difficulty of how to deliver savings within six weeks. I thought that that could be a simple way around the problem, but he tells me that everyone is demanding exactly the same relief.

Ms S Ramsey:

Thank you for your presentation. If you were the Minister and were looking for the Committee's support for your budget bid — the composition of the Executive is cross-party — would you not give all the supporting evidence and documentation to support your budget bid to the Committee or would you leave it hanging so that there are more questions every time the Committee meets?

The Chairperson:

That is a slightly loaded question.

Mr Gardiner:

Is that a case of playing politics?

Ms S Ramsey:

I started by saying "if".

The Chairperson:

It does not make it any less loaded.

Mr Gardiner:

It is still politics.

Professor C O'Neill:

If the basis on which all the calculations are made is opened up to scrutiny and challenged, it will allow not only a greater understanding but a demonstration of transparency, not just in this Committee but externally. The evidence base will get better, and the decisions will, perhaps, be clearer and better as a result.

Ms S Ramsey:

I will touch on the 4,000 job losses. Your paper states that if the Department has scrutinised the expenditure prepared by the Health and Social Care Board, we can move on. I assume that the other side of that is that the local commissioning groups, local trusts, hospitals, and so on, played their part, after which it moved back up the ladder to the Minister. Therefore, based on that evidence and on the figure of 4,000 job losses, we should know where the potential job losses are

and whether they will include catering assistants, domestics or administration staff. If we work up from the Health and Social Care Board to the Minister to put in the bids, all that evidence should stack up from a local area, and we could pinpoint whether there are 4,000 job losses.

Professor C O'Neill:

I understand the train of thought. It may also be the case that it is difficult to achieve that degree of certainty because of, for example, natural wastage, early retirements, women who go on maternity leave and choose not to re-enter the workforce or people on long-term sick leave who then move out of the workforce. I do not think that we could get down to that degree of precision.

Ms S Ramsey:

We could get a better idea rather than simply being told that there will be 4,000 job losses across the North.

Professor C O'Neill:

We could have a better idea.

Ms S Ramsey:

Like other members, I am interested in the demographics, and you are right to point out that between year one and year four, there will probably be a fourfold increase in requirements. It strikes me that the Department is admitting that, in that four-year period, the health of the population will not improve.

At almost every Committee meeting, I raise the issue of Investing for Health. If we need four times more money in year four than we do in year one, we are failing. Where is Investing for Health sitting? Moreover, I read your paper on the basis that I know that the DHSSPS permanent secretary has a back room in the Department of Finance and Personnel. Are we dealing with the fact that the gamekeeper is now the poacher and that they are very clever about what they are putting into the middle? Are we admitting that, over the next four years, we will fail?

Professor C O'Neill:

I cannot comment on the role of the permanent secretary. When the Health Service was set up in the 1940s, there was a notion that there was a reservoir of ill health and that it would be drawn

down, and the Health Service would never be in crisis over funding. Charles is longer in the tooth than I am — I hope that he does not throw anything at the back of my head for saying that — and he will know that there have been perennial funding crises in the Health Service. When one problem is addressed, another is identified. Technologies advance and expectations increase, and one is never trying to hit a static target; it is always just out of reach. In fairness to anyone trying to present a budget asking for more money, we should bear that in mind. For example, the ability to address macular degeneration, the use of stents and cancer treatments are all new things, and I hope that we will get better in the future, which will require even more money.

I have limited knowledge about the work of Investing for Health in Northern Ireland. There are attempts to invest for health, some of the benefits of which we will see over the next five years or so, but we will not see the long-term gains until long after any of us are here.

Ms S Ramsey:

The Department has been at it for 10 years. It is now time for its 10-year review.

Professor C O'Neill:

Perhaps whoever has responsibility for demonstrating that resources have been used effectively should gather that information and present it to you. Oral health is one area in Northern Ireland with which I have some familiarity, and I know that efforts are being, and need to be, made there to address health education and health promotion issues. I hope that they will show fruit quickly.

The Chairperson:

We are rapidly running out of time, and Paul and Tommy are on the speaking list. Is there any chance of my letting you in first on the next round of questions? Did you have a question on something specific?

Mr Girvan:

My question is a general one, which should be easy enough to answer. Given that there was so little detail in the Department's presentation on the draft budget, it is difficult for us to put any meat on it. Therefore, as a member of the Committee, I find it difficult to support any approach that has been brought forward, even down to the Department's estimated figures for what it requires, which is the estimated £2·3 billion shortfall over the next four years. Professor O'Neill, how on earth were you expected to come forward with figures if you do not have the proper

details from which to work? We definitely do not have the proper details, and I appreciate that it is also impossible for you. We are not looking at the full picture. We are seeing only those parts about which certain people are being precious and want to hold on to, rather than disseminating all information to everyone. That was more of a statement, because I cannot see how anyone can come up with anything more concrete from the bunch of figures that have been fired at us. There is nothing in them.

The Chairperson:

To be fair, the Department said that it would form the basis of a commissioning plan, which the board would draft and which would contain the hard stats. Of course, that is a fair bit down the line —

Mr Girvan:

To be truthful, Chairperson, you know the difficulty that we had getting details about management costs and how specific we had to be to get that information. We had to ask very detailed questions, because all the detail was being hidden from us. We even had to decide whether we wanted names, because we could not believe what we were being told. We were told that there would be £6 million in savings, but no savings were made.

The Chairperson:

Professor O'Neill, would you like to comment on that? I know that that was critical of the Department and that you may want to avoid delving into the issue.

Professor C O'Neill:

The job of a scrutiny Committee is to scrutinise, and you are doing your best to do that.

Mr Girvan:

Unfortunately, we are not getting the right information to do it.

The Chairperson:

Tommy, do you have a specific question for Professor O'Neill, or would it be OK to put you on first in the next evidence session?

Mr Gallagher:

It is specific, and I will be quick.

The Chairperson:

Please be quick, because we are running out of time.

Mr Gallagher:

Thank you for your indulgence. You mentioned that efficiencies can be achieved. As we know, the Department's idea of achieving efficiencies is to take easy targets, such as domiciliary care and services for people with disabilities. Do you mean that efficiencies can be achieved over and above those services?

Primary care and secondary care are expensive, and we have not developed local commissioning groups to any great extent. Is it worth developing them to a much higher level than the progress achieved to date?

Professor C O'Neill:

I cannot answer all that. I think that there are opportunities for efficiencies in the Health Service. Are you satisfied that sick leave and absenteeism are what they should be? Are Health Service managers managing as appropriately as they could do? Are commissioning arrangements as effective as they could be? Do opportunities exist in the commissioning group, whether it is centralised or local, to squeeze additional price reductions from whomever is supplying the service or product? It may be the case that further opportunities exist that have not been exploited hitherto.

Tommy mentioned what could be called the Cinderella services; I have written them down. It would be unfortunate and inappropriate if cuts were first sought in the so-called Cinderella services, in the sense that many people in Northern Ireland provide informal care and require support to do that. They are like an auxiliary workforce for health and social care services. If additional strain is put on them, such that they cannot fulfil that role no matter how much they might like and want to, additional strains will be put on the Health Service. The Health Service will feel the strain as those people come out of the equation or as they fall down, become sick or are unable to support their loved ones or family and friends.

The Chairperson:

Thank you, Professor O'Neill. I am sure that you are more than happy to stay behind and listen to your colleague's contribution. Have you driven the whole way from Galway today?

Professor C O'Neill:

No; I was up here on other business on Friday; I will travel down this evening.

The Chairperson:

Your attendance is much appreciated; it is a long journey.