



DÍOSPÓIREACHTAÍ PARLAIMINTE
PARLIAMENTARY DEBATES

DÁIL ÉIREANN

TUAIRISC OIFIGIÚIL—*Neamhcheartaithe*
(OFFICIAL REPORT—*Unrevised*)

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DÁIL ÉIREANN

Dé Luain, 17 Nollaig 2012

Monday, 17 December 2012

Chuaigh an Ceann Comhairle i gceannas ar 10.30 a.m.

Paidir.
Prayer.

Report of the Expert Group on the Judgment in the A, B and C v. Ireland Case: Statements (Resumed)

Deputy Peter Mathews: The debate is resuming from one week ago. I came to the Chamber and listened to most of the contributions. It is important we get this right as a people and as a society. Sometimes, events can occur that give a disproportionate sense of emergency about something that requires reflective consideration.

Our Constitution holds the life of all citizens, from the start of life, in equal value and equal regard. Understandably and rightly, when a woman becomes pregnant and is expecting to become a mother, if her health is impaired and in danger of existence, the situation that has been upheld is that the medical team attending to the woman will do everything in its professional competence to save the woman's life. If, as a sad side effect, a baby is lost, that is one of those hard, sad facts of life. Since the determination of the X case by the Supreme Court, the delivery of medical services and medical care to the women of this country and any women visiting from abroad is as excellent as humanly possible.

As a human race, we are made up of the complementarity of two genders, male and female. Bringing life into existence requires that balance. We are all the sons or daughters of mothers. We may be the fathers of daughters and the brothers or sisters of brothers and sisters. We are a family. The context of supporting the equivalence of life of everybody, whether conceived and yet to be born or living life through to natural death, means we must as a society continue to have the constitutional framework and the application of the values of the framework in conducting our lives.

Hard cases, such as those considered in the courts, do not necessarily make good law. The law is like a map or a road system for life. Sometimes, to have the principles of conduct within society to determine what is valuable and important to uphold for the citizens of the country can be best delivered with a framework of principles rather than the exactitude, or rigidity, of a law.

There have been difficulties with regard to certain cases and those cases are being referred back to the Constitution where there may not be any certain answers, now or ever.

There are people whose vocation and professional lives are dedicated to delivering the services that look after women, not just in childbirth and pregnancy but in general. There are also paediatricians who look after children and other doctors who look after patients of both sexes. The Supreme Court delivered its judgment and particularised a situation where there was a danger to the life of a woman as a result of the threat of her suicide. It could be, given some of the valuable and expert opinions of the medical profession, that the Supreme Court, with its good intention, stepped outside its competency to particularise a condition in which someone was psychiatrically unwell, and that this posed a real or substantial threat to the life. In recent days, some experienced and wise psychiatrists have questioned the wisdom of expressly mentioning a particular condition that might be a real or substantive threat to the life of a pregnant woman. To legislation for such situations, therefore, might not be wise.

The expert group comprised 14 people, including four lawyers. I am not sure of the ages of the members of the expert group. It is interesting to know that we change our views with experience of life and further evaluation of our lives and our family life. An interesting case in this regard is that of the late Anthony Clare, who was a professor of psychiatry and well known to most people here, in England and throughout the world with his wife he had six children. He had a brilliant academic mind. In the passage of time, his views on the situations in which the termination of the life of an unborn baby might be admissible changed. He moved from what could loosely be described as - and I hate these terms - a pro-choice view of the world to what could loosely be termed a more pro-life view. He was short-lived because he got cancer and died in his early sixties. It took the passage of time, the consideration of more than just the narrow spectrum of a legal or technical debate and the understanding of life through living it to come to that view.

This national assembly of legislators should be careful, and we are being careful. People will say it took 20 years to get to where we are. The answer to that is that it is better that we make the right decision and create the right framework of principles for the lives of the citizens of the State, trusting the professionals who have delivered one of the world's service in looking after pregnant women and the delivery of babies to date, trusting them to have the values and principles we have articulated to deliver that service. We are not sure if there were any grandmothers were on the expert group or how many were parents.

A life once it begins has required two people to create it, a co-responsibility of the men and women of this country. We should take our time and not rush to legislate or regulate and we must make sure first principles are correct.

Deputy Eoghan Murphy: I have received more correspondence on this issue than any other since my election to Dáil Éireann, hundreds of postcards and letters, and thousands of e-mails. My consideration of this matter did not begin with the tragic death of an expectant mother and her child in an Irish hospital recently and I do not believe that it did for any Member of this House. When deciding to enter politics, the issue of abortion is a question that immediately confronts us. We are expected to have a fixed position, to be in a camp. People immediately try to put us in a box, pro-life or pro-choice. Such labels or terms are extreme, however, and in no way do they sufficiently capture the complexity of the issue, the genuine uncertainty that people may have, the possibility that one's own thoughts can change by degree over time, or the myriad of different views that are held on the issue. It is far too simplistic.

Since I entered politics I have tried not to be captured by this narrow and reductive attempt by others to frame my own views on the matter. There is a responsibility with this job to try to stand above the fray when deciding upon national issues, to remove oneself from temporal considerations of the matter at hand and consider the longer term consequences, to divest oneself of any electoral considerations, particularly on matters of conscience, and always to exercise one's own judgement as distinct from the opinions of those one represents. This is essential. Every single view possible on this issue is held within my constituency and within my party. How can I represent each view independently and coherently? I cannot; I can only use my own judgement in the matter, or else I betray them all.

There has been some talk around this issue on the necessity of having a free vote when the matter is finally decided on by Government. I support this idea, and not just on this issue. What is a vote worth if it is not free? People fear a breakdown of the whip system if we remove or relax the whip on certain issues and some argue that it undermines the party system. I do not accept these arguments. In other, older parliaments, there is such a system and I believe these parliaments and their political parties to be stronger for it.

On this issue parliamentarians should be allowed to vote based on what they actually think, and to defend that vote, rather than being forced in to a position they do not agree with. By enforcing the whip on this issue there is a risk that we could possibly end up weakening the decision that we ultimately take. Who will be served by such an outcome?

To come straight to the matter, I do not favour abortion. That is my own personal view on this issue but do I have a right to force that view on another person? Whether as a legislator or not, do I have a right to tell a woman what she must do with her body? Does the State have that right? As the State has a responsibility to all our lives, it has a responsibility to unborn life but I do not believe this responsibility to be superior to the State's responsibility to a woman's life, her mental health or her health. I believe that the State has a responsibility to provide for the lawful termination of pregnancy in certain circumstances and some of these circumstances would require a change to the Constitution.

Saying that a person can always travel if absolutely necessary is not the answer. I do not believe I have the right to tell another person what she can or cannot do when it comes to this most important of issues, and I do believe that the State has a responsibility here to make certain provisions in law. In so far as the report of the expert group on the judgement in *A, B and C v. Ireland* is concerned, I thank those people involved for drafting this report. Although no explicit direction is given, it seems clear to me that the option outlined in paragraph 7.4.3 is the most suitable: legislation plus regulations.

Deputy Michael Conaghan: I well remember the 1983 referendum campaign. It was a bitter, vicious campaign. During the campaign I held a public meeting in my local electoral area. There were no more than ten people present, among them a future President of Ireland, Mary Robinson, and Dr. Paddy Leahy, the general practitioner in Ballyfermot who was a fearless advocate of women's rights throughout the campaign. Also in attendance was a Jewish doctor from Inchicore and a few women. I wonder if I held that meeting now in the aftermath of the tragedy in Galway how many would attend. I believe the hall would be overflowing. Public opinion at that time was fixed firmly against the message we were trying to get across, the message that women's health in all its dimensions must be the overriding priority. Those of us who campaigned against the Constitutional amendment were shunned by a large section of society. Names were read out from the pulpit by furious priests and bishops and doors were slammed

in our faces, etc.

Since the early 1980s, the debate on legislating for abortion in certain circumstances has always been drawn straight to the extremes. As someone who favours the availability of abortion in limited circumstances, I still consider myself to be pro-life. Killing babies is wrong, let there be no doubt about that. Despite some of the more extreme rhetoric on the anti-abortion side that is not what this is about. This is about achieving a balance that gives due regard to the life, health and well-being of women. Difficult situations exist and arise. Doctors are regularly faced with difficult decisions whereby the life of a mother is in danger. It happens and when it does we must choose on the side of a woman's life. Doctors must be confident that they can make the right decision in the interests of women's health within a clear legal framework free from the spectre of 150 year-old legislation that would have them treated as murderers.

At the heart of the dilemma is the failure of the Constitution and the law to adequately express how to tackle these situations. The legal position as it stands limits the choices a doctor has and, as a result, endangers women. This has been dramatically demonstrated by the case of Savita Halappanavar. Although this tragic case is still under investigation it seems to me that it was preventable; it should not have happened. An option that could have saved her life was closed off to the doctors because of the legal uncertainty.

To atone for this tragedy we must act in the Dáil and introduce the necessary and long overdue legislation. We need to make political decisions to minimise the risk. For too long we have failed to remove the obstacles to protect women's safety during pregnancy and childbirth, the most vulnerable point in their lives. There have been other tragedies many of which have never reached the pages of the national newspapers because women's health has never been properly guaranteed. Therefore, we must act to remove the risk, the burden and the dread and we must act now.

Tragedies such as the recent one in Galway manifest themselves in various forms and at various times. We cannot go back to the days of women being afraid to go to hospital for fear of their lives and instead being driven down the backstreets and into dark basements for illegal, unsafe abortions. The story of nurse Mamie Cadden, who performed abortions in Dublin in secret in the face of the law and who was sentenced to death in 1956, is an example of the desperate choices women were forced to make. Nor can we continue to rely on an English solution to an Irish problem. Abortion is available to Irish women, at least those who can afford it, in England. A total of 4,000 young Irish women avail of this every year. This is not acceptable. These women are forced to travel, often alone, without any support and, on their return, they feel they must hide their shameful secret. They endure an emotional ordeal the likes of which I can only imagine, without access to the psychiatric support etc. they need. Any framework that forces women into this position is wrong. If a woman finds herself in a position where she believes she has no option but to terminate her pregnancy, she must have access to support and not be cast out on her own.

The 1983 amendment is a cul-de-sac into which we have pushed women's lives and we have sent them into this cul-de-sac at the most critical time in their lives. For the pro-life movement, the 1983 amendment was the solution to any future challenge. It put two lives - that of the mother and that of the unborn child - on an equal footing but instead of answering any future questions, this measure has made these questions more difficult to answer. While the idea of another referendum on abortion has, to date, been propagated only by the pro-life side, I also believe such an initiative may be needed to provide further clarity.

The campaign for reproductive rights and women's rights is not new. It did not start last month, last year or even 20 years' ago. A clear legal framework in which pregnancies can be legally terminated has been a political imperative for over 30 years but successive Governments have failed repeatedly to act. I have great admiration for the work of Jim Kemmy. Thirty years ago at the helm of the Democratic Socialist Party, DSP, he charted a practical and courageous course. The DSP was a relatively small party but size did not limit its vision on abortion, Northern Ireland, Europe, workers' rights, the patronage of schools and many more subjects. The course it laid out on abortion was not a popular one at the time but one would have to admire the courage and foresight that Jim Kemmy and the DSP demonstrated.

At that time, one church set the moral parameters of political discourse and no established party was prepared to take it on. The orthodoxy at the time was that women had to take their chances and take their lives into their own hands. Jim Kemmy publicly challenged this orthodoxy and our entire political culture, and he paid a political price for it. The position that Jim Kemmy outlined and defended in the face of widespread opposition would have prevented many of the terrible, gruesome situations which have arisen over the past 30 years. He firmly believed that an absolute prohibition on abortion could not be justified as it may be necessary in certain, limited circumstances. Had his course of action been followed, X would not have needed to go to the Supreme Court in such tragic circumstances. Twenty years later, C would not have needed to go to the European Court of Human Rights. Although all the facts are not yet clear, I believe that had Jim Kemmy's course been followed in 1983, the circumstances of the tragic death of Savita Halappanavar may never have arisen. The following is an extract from the DSP's "Outline Policy on Women's Rights", first published in 1982:

The woman who finds herself with an unwanted pregnancy is presented with a catch-22 situation. Does she hide herself in a maternity hostel for 6 months, in the process losing her job or missing essential schooling? Does she face the social ostracisation of neighbours and work-mates for 9 months and then go through the trauma of adoption? Does she try to keep her child and spend many years in a desperate economic struggle, all the time apologising for her child's existence? Or does she take the boat to England and have an abortion? Thousands of Irish women are annually making the latter choice. Many of these women are pregnant as a result of the inadequacy of contraceptive facilities here. Many are extremely young and pregnant through ignorance due to the lack of adequate sex-education in schools. Some are pregnant as a result of rape. Under Irish law, they are criminals if they opt for abortion. The morality which says to these women and girls that they must suffer the consequences, and which at the same time, ostracises the unmarried or widowed woman who is pregnant, must be exposed for the hypocrisy it is. The D.S.P. while opposed to indiscriminate abortion would consider it as a solution: where a woman's life is endangered by pregnancy; where pregnancy has resulted from rape or incest; and to the terrible problems of congenital abnormality of the foetus which makes survival outside the womb impossible. The DSP confirms its view that this is a perfectly moral position to uphold in a pluralistic Irish society.

This policy, considered barbaric by so many when it was first outlined in 1982, appears so reasonable and sensible to the majority of Irish public opinion 30 years later. A generation later, our political culture has broadened and finally caught up, and as we move forward, I suggest that this framework may well be the best guide. This sensible, moral position cost Jim Kemmy his seat in Dáil Éireann in 1982. During this campaign, he was denounced from the pulpit and pilloried by the local press, with the *Limerick Leader* writing "Abortionist Jim Kemmy is hit-

ting below the belt” and “let the people decide which is the better way – the pro-life way or Kemmy’s way of death”.

11 o’clock

His brave and prescient position was exploited by his political opponents and his seat was lost. This was the price he paid for his foresight and commitment to women’s rights. I am very happy that 30 years later public opinion has shifted so far towards what Jim Kemmy believed. I only hope now that the Members of the House honour his memory by doing the right thing and not shirking their responsibility as legislators and take the long overdue steps needed to protect women’s lives.

Deputy Derek Nolan: I commend my colleague, Deputy Conaghan, on what was a very thoughtful speech on his personal experience and engagement with the issue over the past 30 years. I also commend the late Jim Kemmy and another former Member of the House who lost his seat for taking a courageous position on the issue, namely, the President, Michael D. Higgins.

As a constituency representative of Galway West I wish to express my deep sympathy to the family of Savita Halappanavar, her husband Praveen, their relatives in India and their friends in the Indian community in Galway. They and their family were affected by a huge shocking human tragedy and inquiries are under way. I look forward to seeing these inquiries obtaining responses and clarifying the facts at the earliest opportunity.

During my short time in politics the issue of medical termination of pregnancy has been the most divisive and polarising issue with which I have had to engage. It has been around for a long time, since the 1983 amendment when people such as Jim Kemmy, Michael D. Higgins, Mary Robinson and others took the brave steps outlined by Deputy Michael Conaghan to fight for a more rational and nuanced approach recognising the vagaries of life, the grey areas which can creep into discussions and the circumstances which may require compassion and leniency rather than strict orthodoxy.

The X case resulted less than ten years later in 1992, and the Supreme Court upheld a different interpretation, stating there is a right to termination where there is a real and substantial risk to the life as distinct to the health of the mother. This decision caused uproar throughout the country in the time before I was involved in politics. It is interesting to look back now at the viciousness of the exaggerations and hyperbole involved in the discussions because the same exaggeration and hyperbole has come back into the discussion again today. Nothing dramatic has happened in the past 20 years. It is also interesting to note what happened in the aftermath of this decision. Three referendums were put to the people in which they were asked three distinct questions, namely, should a woman have a right to travel to have a termination to which the people said “Yes”; should a woman have the right to information about accessing services abroad so she can know where the services are and how to procure them to which the people also said “Yes”; and should we overturn the Supreme Court decision which stated suicide is a grounds which justifies risk to the life of the mother to which the people said “No”. The people deliberately and with discernment voted “Yes” in two cases and “No” in the other.

We should not forget the details of the X case. A 14 year old girl left at home to be minded by a family friend was raped and impregnated. She was left in a terrible mental health state and suicidal. She wanted to travel to the UK to terminate the pregnancy. This is the case we

are discussing. We are not speaking about a woman of majority age deciding she wanted to go for another reason. We often forget the cruel and human story behind the X case. It is always worth keeping that in our minds.

On the judgment in *A, B and C v. Ireland*, we must be clear, first as legislators. We cannot distinguish ourselves from this as legislators. The European Court of Human Rights, of which we are a signatory and which is designed to uphold human rights in Europe, makes clear that we must implement the law that our country has on its books, we must make clear when a right to termination exists, we must make clear how that right is assessed and we must make clear how that service is to be provided. Let us never say anything other than that the European Court of Human Rights is telling us that our law, that has been voted on by the people, ought to be implemented. That is what it is, nothing more. We are not being told we must offer services. We are being told that our existing law, that we have voted on and that the Supreme Court has dealt with, must be implemented. We are legislators. Indeed, we are members of the community, representatives and members of families. We are, as Deputy Mathews stated, fathers, grandfathers, brothers and sons, but we are still legislators and there is a law in this country that needs to be implemented.

I note the atmosphere within which this debate can often take place. The downright viciousness of those on the extremes of the pro-life lobby cannot be underestimated. I campaigned in the past general election to legislate for the X case, this extremely specific set of circumstances that is the law in this country. There were protests outside my office. There were illegal posters put up all around my constituency stating that Labour would introduce abortion on demand and there were 200,000 abortions per year in the United Kingdom. There were leaflets handed out at churches, one of which was given to my father telling him that the position on which I was campaigning was a pro-choice abortion-on-demand service. That is what this discussion often becomes saturated with, this invidious atmosphere with vicious uncompromising, unrealistic, unnuanced and non-factual arguments. However, I have real respect for persons of genuine belief and reasoned debate who are of a pro-life position because it is a perfectly tenable and respectable place to be, but I would argue that what we are discussing today, which is the implementation of the X case ruling, is perfectly compatible with and, indeed, should appeal to those of a pro-life position.

The X case sets two issues. The first is where there is a real and substantive risk to the life, as distinct from the health, of the mother. We are saying that a termination should be afforded where there is a risk to the life. We are not concerned here with any other reason, but about life-saving treatment. Where a termination is a life-saving treatment to the mother, it must be available. That ground, or area where that decision can be made, has not been clarified by law. There are doctors, including the highly respected Dr. Peter Boylan, former master of the National Maternity Hospital, who have stated that where the risk is clear there is no problem and it works fine, but there are grey areas. There are situations where doctors, practitioners, nurses, etc., worry about these grey areas. One such is the need to make a critical medical decision quickly and in good faith. Another is the fear of the risk that one could be reported by a colleague who holds a contrary opinion with the result that one could be prosecuted under the Offences Against the Person Act 1861. We need to give doctors legal certainty, clarity and assurance when they are acting in good faith to save the life of a mother.

The second issue which causes major problems in terms of the public discourse is the ground that a risk to the life of the mother includes the risk of self-destruction or, as we call it in more everyday language, suicide. It is worth listening to the experts who operate in this area. One of

those to whom I have listened on the radio is Dr. Anthony McCarthy, a consultant perinatal psychiatrist. Another, and with whom I have discussed this issue, is Professor Veronica O'Keane of Trinity College, Dublin. As professionals, they are very much of the view that the suicide issue is a real one that has to be taken seriously. These people of sound medical practice are a rock of sense. They say the suicide issue is serious and the assessment of it should not be a tick-the-box exercise where we simply go through the motions. At the end of the day, their duty as doctors is to the mental health of their patients. That assessment therefore should be real, not a tick-the-box exercise.

In our debate, we run the risk of talking about women's suicidal feelings as something that should be ignored or stigmatised. The cavalier manner with which the risk of suicide and mental health is dismissed by some people on the pro-life side of the argument is very worrying. We regularly have debates in this House on suicide, depression and destigmatising mental health. Yet as soon as it comes up as an issue to do with the termination of a pregnancy it is to be dismissed as fake. As one psychiatrist said - I think it was Patricia Casey - there is a book one can get which will tell one how to fake suicidal tendencies. She said that one can just read the book and have one's script ready when one goes in to the doctor. It is appalling and scandalous for someone who works in our medical services to be saying that kind of thing to the public, including women, in this country. Women in my constituency have told me that the last person they would go to see - and from whom they would refuse treatment - is that lady. I will leave it at that, a Cheann Comhairle, and I apologise for straying.

An Ceann Comhairle: Please be careful about questioning people's professionalism and mentioning names.

Deputy Derek Nolan: I agree and I withdraw that.

An Ceann Comhairle: Thank you.

Deputy Derek Nolan: The two other perinatal psychiatrists, however, said that suicide in pregnancy exists and is real. For the majority of women the last thing they would do would be to suggest or prescribe a termination. It is a mental health issue and there are ways to treat it. One treats it as one would the risk of suicide in other areas. Nonetheless there are examples, known to the medical professionals, where it is prevalent to such a degree that this approach should be taken. If only one woman per year or per decade is at such risk, that woman needs to be protected. She needs to have her rights vindicated and her right to life - for that is what we are talking about - as a mother and as a woman protected. The reality is that at the moment we send people to England and they are afraid to come forward.

When we are discussing this in future and if we get to deal with legislation, the doctors have asked for two options. One concerns how to deal with the majority of cases of women who will not require a termination. They will require medical help and counselling. The second concerns dealing with those exceptional cases that may require it. We need to be cognisant of both possibilities when we are debating and putting forward legislation.

I also wish to refer to some of the arguments that have come forward against this matter. The first one is that the Supreme Court judgment is flawed. That is a very cavalier thing to say. It was said in this House on a number of occasions that five members of the Supreme Court got it wrong, even though in two referendums the public upheld their view. Simply refusing to accept the judgment does not make it flawed.

The second argument, which we hear a lot, is that Ireland is one of the safest places in the world for women to give birth. I do not deny that but the safest country is Italy which has a much more liberal regime on these matters. Therefore it is a nonsensical argument and it should stop being cited.

The third argument is that we are going down the route taken in the UK. This is the most unfair argument of all because the UK law is based on the 1967 Act which refers not to the life of a woman but to her physical or mental health. It refers to mental or physical abnormalities or serious disabilities. As none of those scenarios would happen in Ireland, where a constitutional protection is in place on the life of the unborn, this again is a complete red herring.

The fourth argument one hears, which is technical in nature, is that the Supreme Court did not hear medical evidence when it was making its decision. This goes back to the idea that the judgment was flawed. However, the Supreme Court never hears evidence. It is an appellate court that hears appeals from the High Court, which hears evidence. Moreover, in the instance of the X case, the risk of suicide was accepted by both sides and therefore, it never came into issue.

I thank the Ceann Comhairle for his indulgence and will conclude by noting that I am very aware that as a man, I will never be in this position. However, I do not believe this precludes me from having an opinion on the subject. I like to think that I represent women, that I represent my mother, my sister, my friends, my colleagues and people with whom I work. Members never should forget they are discussing scenarios in which a woman's life is at risk. They are discussing very limited circumstances, as I have outlined on the issue of suicide, in which it may occur. However, the broader issue of the right to life and the clarity for doctors must be clarified. Finally, I note the X case judgment is the law in Ireland and Members must legislate for it because it is the law of Ireland that has been upheld twice by the people in referendums. The grounds to which it refers, that is, a real and substantial risk to the life of the mother, are nothing short of a pro-life position and everyone should be able to subscribe to protecting that and to vindicating that right.

Minister for Children and Youth Affairs (Deputy Frances Fitzgerald): I am pleased to have the opportunity to make a statement on the report of the expert group on the judgment of the European Court of Human Rights in the case of *A, B and C v. Ireland*. I first wish to put on record my appreciation for the work of the expert group and in particular, that of Mr. Justice Seán Ryan, for the commitment, sensitivity and consideration the group has given to this complex issue. Anyone who wishes to speak on this issue really ought to read the 55 pages in this report for its preface, the summary, the legal provisions, its clarity in respect of the cases that have arisen thus far and its summary of the key principles. It has been done very well.

The European Court of Human Rights accepted that Article 40.3.3° of the Irish Constitution provides it is lawful to terminate a pregnancy if it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, of the mother, which can only be avoided by a termination of the pregnancy. This remains the constitutional position today, unaltered by the decision of the European Court of Human Rights. The constitutional obligation also on the State is, by its laws, to respect and as far as practicable defend and vindicate the right to life of the unborn and these provisions must of course be borne in mind in the mode of the implementation of the judgment.

In the *A, B and C v. Ireland* ruling, The European Court of Human Right requires us to give

practical effect to our constitutional position. The report of the expert group recommends a series of options on how to implement this judgment, taking into account the constitutional, legal, medical and ethical considerations involved in the formulation of public policy, as well as the overriding need for speedy action. The report provides a range of options that must be considered carefully. In theory, Members present today should agree on at least one thing, namely, the Irish Legislature has grievously failed in its duty in respect of abortion. It should be easy to agree on that as a first principle. The European Convention for the Protection of Human Rights and Fundamental Freedoms is an international agreement that Ireland has signed and ratified and which, in consequence, is legally binding. This duty to comply with the judgments of the European Court of Human Rights is an integral part of the scheme of the convention. Although these Houses have failed to legislate on this issue for more than 20 years, the reality is that over the past two decades, few Deputies or Senators have been idle on the matter or uninterested or without conviction. Members stand today at yet another infinitely painful point in a two-decade sequence of difficult and painful cases, Irish and European case law, reports, Green Papers, deliberations by an Oireachtas constitutional committee and periods of intense public debate. Some of my colleagues in this House are young enough not to know much about the campaigns and debates of the 1980s and 1990s but both were impassioned. It was often the level of passion which rendered problematic, if not impossible, the task of legislating.

We must now repair the gap, the lack of trust and the uncertainty that has now developed between the people, their legislators and the maternity hospitals with regard to pregnancy. We must make explicit the standards and regulations guiding the delivery of one of the best maternity services in the world. We must, in short, act as the Government pledged it would in the light of the advice of the expert group. How we act will have a powerful if indirect effect on the confidence of women, their partners and families in the consistency and high standards of care provided by Ireland's maternity services.

Let us also face another reality for Irish women. As of this year, more than 4,000 women travel annually out of Ireland for terminations. These are daughters, wives, partners, sisters, mothers, friends and work colleagues. They range in age from the very young - some 11% are teenagers - to the 37% who are aged 30 or older. They are ordinary Irish women who for many different reasons face a pregnancy they believe they cannot continue. Some have sought counselling or support before making the decision but many know that despite the support and promotion of counselling and related services, there is an underlying Irish code of "Don't tell, just go."

The people involved in such cases frequently find themselves ridden by internal contradictions. One woman told me she voted "pro-life", as she termed it, in the 1983 referendum, and she also told me her daughter had a very serious crisis pregnancy, and she had taken her for an abortion. She said, "I voted pro-life to stop irresponsible demands for abortion". That makes sense and it makes no sense, that is, just as it makes sense to say Ireland does not have abortion, it makes no sense when we know Irish women travel to have terminations in our neighbouring jurisdiction. It makes sense to be fearful of change and it makes no sense to brand women as being duplicitous and untrustworthy, likely to claim suicidal thoughts and pull the wool over the eyes of the medical profession in an effort to seek the option of an abortion.

Since when has it become permissible to make such bald and dismissive statements about women and people presenting with serious mental health problems? Since when has it become permissible to resist the idea that pregnancy might trigger or could exacerbate existing mental health conditions? Let us not go there or attribute ruthless, uncaring duplicity to women we

do not know and who in the distant future may have a crisis pregnancy. We do not progress in that way.

Where we have progressed it has come through respectful responses to reality. Our attempts to reduce the levels of unplanned pregnancy and provide better support and encouragement - there is history in that regard - to women in choosing to have their babies have, I am thankful, made some progress. We have a long way to go and I certainly favour a more determined and intensive level of attention to the work of the crisis pregnancy unit of the Department of Health. That was formerly an independent agency but it is now working as part of an interdepartmental and inter-agency national action plan.

This debate has specifically been about a failure to act in the wake of the X case and in light of the cases which have arisen since. It has resulted in an unacceptably grey area in medical practice. The masters of some of our maternity hospitals and many other health professionals insist that clear law, supported by equally clear regulation, is essential. As we move to meet this need, we must not segregate women into the selfish majority who are not to be trusted in this area and the tragic few hard cases as to do so would be irresponsible and shameful.

This Government is committed to doing what no Government has done before. We will make the necessary changes to bring clarity to this issue by regulation, legislation or a combination of both. After years of inaction, we will deliver a clear framework for medics and women in their care whose lives are at risk. We must also take some other steps. We must acknowledge in our health statistics information on Irish women who travel to other jurisdictions for terminations.

We must also acknowledge the painful reality for those expectant families who are faced with the news that their baby will not survive outside the womb. These tragic cases of fatal foetal abnormality, as the A, B and C report acknowledges, are generally considered to be outside the principle arising from the X case. I recently met a woman who experienced such circumstances; her story is representative. Sarah and her husband John were delighted to be pregnant in 2009. Scans taken at the Coombe Hospital in the 13th week showed a pregnancy that was progressing normally and later, in the 26th week, that Sarah and John were expecting a daughter. Within days, however, the position changed as a further scan showed a fatal foetal abnormality. The couple's daughter had anencephaly - she was not forming a brain - and would not survive outside Sarah's womb. Sarah suddenly knew that medical treatment which could save her baby was not available and her daughter would not live. She assumed that a Caesarian section would be scheduled because it did not occur to her that anything other than this would happen. However, she then found herself in the twilight zone the Irish health system becomes when such a crisis arises. Sarah's circumstances were not normal and the diagnosis was clear. She was informed she could travel to Britain to be induced in an English hospital. She, her father, who is from the midlands, John and his mother sought and obtained in England the care Sarah needed. Although it was clear to Sarah and her family that her doctors were unable to act in her circumstances, at least they were aware of all the options, which is not the case for everyone. What is evident from anecdotal evidence is that when such circumstances arise, there is no consistency in care, advice or practice.

Some question marks have also arisen about the accuracy of Irish statistics on maternal deaths. We must have accurate data on maternal mortality, the number of diagnoses of fatal foetal abnormalities and the care given to women in such circumstances. We must face reality by gathering statistics in these areas to understand precisely what is happening in our hospitals.

We cannot have grey areas on this matter as the position is not fair on the medics and women involved. As I stated, a review is also needed of the crisis pregnancy division of the Department of Health to identify what more we can do about the continuing unacceptably high rate of crisis pregnancy in Ireland.

Whatever guidelines are developed as a result of the events of recent months, they must be enacted in the common good and respect the fact that the people who live here are of many faiths and none. No patient in a State hospital should be ever told his or her care is driven by anything other than our laws and best medical practice. Let us stop the discourse that is based on the illusion that we do not have abortion in Ireland. What we do not have are the hospital services and legislative framework and the reason the current position is sustainable is that our close neighbour provides both.

Can the legacy of recent weeks and our accumulating understanding of our flawed system lead us to holding a national debate which grasps the reality and complexity of crisis pregnancy? I sincerely hope so.

Minister of State at the Department of Finance (Deputy Brian Hayes): I place on record my appreciation of the work done by Mr. Justice Ryan and the other members of the expert group. They have done the State a great service, not just in terms of the way in which the report was written, but also the way in which the options were clearly set out therein. I encourage everyone to read the report. As the Minister, Deputy Fitzgerald, stated, it is written in clear language and people both inside and outside the Houses will understand the full import of its contents.

I will outline where our responsibility lies. The Houses of the Oireachtas comprise the elected representatives of the Irish people. As legislators, we have a duty under the Constitution to act when the situation demands it. We have delayed for far too long. Twenty years ago, the Supreme Court outlined what needed to be done. Over the years, many medical professionals working in this area have also called for legal clarity. Most recently, the European Court of Human Rights has demanded action.

The failure of successive Governments to act has put the lives of women at risk. Too often, we only respond when a crisis develops. This generation of legislators is now called upon to exercise its duty. We must not be afraid to do so. Legal clarity and a full, proper legislative response to the issues contained in the X case ruling of more than 20 years ago are required.

We are faced with the complex work of drafting a legal framework. Our work must be guided by the Constitution and the Supreme Court's interpretation of it. We have a duty of care to this and future generations of women. Women are not some abstract concept. They are our wives, partners, daughters, mothers, sisters and neighbours. They are the ones who must take on the joys and burdens of child bearing. I sometimes believe that, if men had the responsibility, there would be few children in the country. We must do everything possible to lessen the fear and risk for women who are pregnant or may become pregnant. In this debate on these complex issues, I will give greater weight to the opinion of women in all of its diversity.

We also have a duty to provide greater legal clarity to doctors and other health professionals. We must accept that it will never be possible to provide for each and every eventuality. In a real life risk situation, the wishes of the person carrying the risk must be given the greater weight.

We must also be guided by a thoughtful, ethical approach and by respect for human life

in all of its forms. Science and medicine should inform our thinking, as should our cultural and belief systems. Science informs us that life is a continuum. Human life has its beginning during the process of fertilisation, during which each of us obtains a unique genetic heritage. However, on an ethical and philosophical level, it is important to distinguish between potential and actual. That new beginning is not yet an actual human being, but it has the potential to be so. A human being is a process of becoming, through gestation, birth and beyond into a full adult life. Article 40.3.3° on the unborn's right to life expresses the strongly held view of the people that all human life deserves respect and protection.

The abortion debate in Ireland and other countries has been characterised by extremes. At one end of the debate is the absolute right of the mother to choose irrespective of the stage of pregnancy or the development of the unborn. At the other extreme is the view that a full human being is created at fertilisation and that its life must take precedence over the health of the mother irrespective of the circumstances. Indeed, it is one of the great ironies of recent Irish history that the so-called pro-life campaign and its refusal to listen to others facilitated the introduction of abortion to Ireland.

I reject both extremes. I reject absolutes. Life is not lived in some kind of ideal world of platonic absolutes. Life is not lived in black or white. Life is lived by real people in real time. In the midst of enjoying the pleasures and happiness that life brings, we must also deal with the mess that comes from being human.

Where a pregnancy is not sustainable for medical reasons, the decision to end the pregnancy must rest with the woman in consultation with the medical team. Where a pregnancy triggers a new serious medical condition because of an existing medical condition and where those conditions pose a real and growing threat to the health and possibly to the life of the mother, decisions on termination must rest with the mother in consultation with the medical team.

The expert group is correct in its interpretation of the Constitution that where it is proposed to terminate a pregnancy, every effort must be made to save the unborn. Obviously, important and difficult clinical decisions may must be made surrounding the viability of the unborn and the associated issue of the timing of termination. The insertion of Article 40.3.3° into the Constitution had unintended consequences. It is important that the legal framework being considered is open to maximum scrutiny and debate. That is why it is right that the Government's proposals in the first instance will be discussed at the relevant Oireachtas committee and in the plenary session of this House.

Many thousands of Irish women have terminations every year, as stated by the Minister, Deputy Fitzgerald. They have them in Britain. It is estimated that perhaps 150,000 Irish women may have had terminations. We also have a duty to consider how the numbers might be reduced. Unwelcome and unwanted pregnancies are always going to happen. Women need effective and practical support in such situations.

In all the recent coverage on this issue, a letter by Canon Stephen Neill in *The Irish Times* on Thursday, 3 November most accurately reflected my views. He wrote in that letter the following:

The only hope for a reasonable debate and a mature and responsible approach to this issue which we have never faced up to as a nation is for the middle ground to find its voice. It is possible to be both *pro-life* and *pro-choice*. We can simultaneously respect the right to

life of the unborn and the life of the mother.

That is the challenge facing us as legislators, to find that middle ground, where we can show reverence for all human life and respect the lives and difficult decisions faced by real people as they live their lives in ever-changing times.

Six weeks before Dr. Garret FitzGerald's passing, I had an opportunity to meet him for a lengthy lunch and conversation. It was a great privilege to discuss with him a range of issues that we faced at the time but also issues that arose during his time in politics. At the end of our discussion I asked Dr. FitzGerald the issues on which he made mistakes during his time in politics. He spoke honestly and eloquently about his deep regret in agreeing to the demands for a constitutional referendum on this issue in the early 1980s. The issue became, as he described, entangled in party politics and in the fervent political atmosphere of the time, where there were three general elections in 18 months.

Dreadful mistakes have been made on this issue since the early 1980s. I believe, however, that the majority of people, while opposing an abortion regime, want this issue resolved within the context of the Supreme Court ruling on the X case and the legal and regulatory certainty that follows that for women and their doctors. The Constitution is the Constitution. Under the Constitution, the Supreme Court has the sole right of interpretation. Ignoring its interpretation of more than 20 years is no longer an option for the Government and the House.

Deputy Regina Doherty: I thank Mr. Justice Sean Ryan for the work and commitment he and his team put in during their deliberations, given their terms of reference. For me, as a new Member of the House, he produced a report that was exceptionally easy to read and understand, particularly given the difficult topic on which he had to deliberate.

We have been talking about this subject for years. It is an intimately personal issue. People say all politics is personal but this issue is particularly so. We do not think just about abortion or medical interventions. We are talking about raw emotions and uncanny feelings when discussing the lives of our loved ones, mothers, brothers and sisters. When we are confronted with emotional challenges they generate different feelings in us and in the past number of years this issue has grown to be a very raw subject for some people. I have struggled with it a great deal since Deputy Clare Daly introduced the first Bill on the subject.

I have thought a great deal about the eighth amendment, what it means to me as a human being, a Catholic and a mother and the exceptions to that amendment which we have discussed in recent months, that is, what they are, how we can deal with them and how to be compassionate and not considered cold feeling. I have done a great deal of soul searching in the past couple of months and what I keep coming back to is how much I cherish life - I refer not just to my own life but all life, the lives of the people I love and the lives of the people in our community - and how much respect each of us has for the gift of life. Many people will not feel the same as me but I believe life is a gift and something to be cherished and respected. It must be thoughtfully considered when discussing abortion.

Human beings inserted the eighth amendment into the Constitution in 1983 because they are full of kindness and understanding. That is the way we must approach the current issue presented to us. One would have to be the most unfeeling and uncaring person not to appreciate the pain and tragedy of the loss of Savita Halappanavar a number of weeks ago. Notwithstanding that, however, we must look at the medical treatment and interventions that happen each day for

women in this country and stop saying the reason we must deal with this issue is that there is a question mark or some uncertainty in that regard. The uncertainty for many of us stems from the issue of including suicide in legislating for the X case. It is difficult for somebody who has a genuine fear that once the door is open it will not be capable of being closed. Deliberating on this in the Oireachtas committee in the next few weeks will provide us, hopefully, with some type of mechanism or architecture for allaying the genuine fears that exist, particularly for me and some of my Fine Gael colleagues.

At the end of this process I want to find myself in a situation where I can support legislation that will provide for the best medical practice and interventions. The journey I am on at present is to try to understand and appreciate how we can provide in legislation for something which, for me, is as abstract as the ruling which states that where it is a matter of probability there is a real and substantial risk to the life, as distinct from the health, of the mother it can be avoided only by the termination of pregnancy. I have real difficulty with that. I cannot genuinely understand how that could be a treatment for or resolve any issues for people who are suffering from mental health issues or severe depression. That will be my difficulty over the next few months. However, I am very open minded and willing to sit through the Oireachtas committee hearings on 8, 9 and 10 January and the deliberations and debates in the House thereafter. I look forward to it.

One thing that upsets me in this debate, however, is talk about the differences in when some people believe life genuinely starts. I heard a quote yesterday which sums up the issue for me. It is that we do not grow into human beings, we grow as human beings. I genuinely believe that life begins at conception and that is why this debate and the treatment of this issue must be so respectful. Life is there from the moment of conception and we must tread exceptionally carefully.

Minister of State at the Department of Health (Deputy Kathleen Lynch): I thank all the Deputies for their thoughtful and considered contributions to this discussion. We have heard many differing views and they will be useful in informing tomorrow's Government decision on the option to be pursued to implement the judgment of the European Court of Human Rights in the A, B and C v. Ireland case. To conclude this discussion, I restate the Government's commitment to implement this judgment and to bring the required legal clarity to the issue of lawful abortion in Ireland. The decision by the Government will be within the confines of Article 40.3.3° of the Constitution and its interpretation by the Supreme Court. The joint committee on health and children, as was mentioned by Deputy Regina Doherty, will commence its public hearings on the implementation of the options chosen by the Government before the resumption of the Dáil in January. We all look forward to that.

It is important to restate the position. I listened to the contributions and I would not disagree with the majority of them. When the Government decides to legislate or to legislate with regulations and I believe it will be a mixture of both - it is no longer an option to do nothing - it will not meet the expectation of the majority of Irish people. The eighth amendment to the Constitution and the Supreme Court's decision leave us in a position that all we can do is legislate or regulate in such a restrictive manner that there will be another case that will demand our attention in the future. People expect that when the Government acts in this case its action will be encompassing and deal with the issues that face women every day of the week, but that is not the case. What we will be able to do will be so limited that there will be another case.

When are we going to mature? My position is very like that of the Minister, Deputy Fran-

ces Fitzgerald. I am not on one side or the other. Indeed, as the Minister of State, Deputy Brian Hayes, correctly said, the middle ground needs to find its voice, and I am very much on that ground. When will we give doctors and the people who treat women certainty in terms of health? We all know that women have completed a pregnancy despite medical advice that it would cause serious impairment of their health for the rest of their lives. It is very difficult to know when one's health deteriorates to such an extent that it will result in one's life being lost. That is the difficulty. When will we allow women, in consultation with their medical teams, to make decisions for themselves?

The key to all of this debate is the issue of trust. Do we trust our mother, sister, aunt, friend, wife or partner or are we putting women in a position that they will have to feign insanity to do what they believe is the right thing? Nobody wants termination of pregnancy as a contraceptive. However, trust is central to this argument. We will now either legislate or legislate with regulations. Mark my words, however, there will be another incident, and we will have to return and confront this issue again. What we are about to do is far too narrow.

I genuinely appreciate everybody's point of view on this issue, but more tolerance and debate will be necessary because it is not over yet.

Deputy John Browne: After tomorrow's Cabinet meeting, will the House be fully informed of the decision of the Government? The Taoiseach promised that two weeks ago.

An Leas-Cheann Comhairle: Today we are having statements.

Deputy Kathleen Lynch: Is my understanding that all Cabinet decisions will be made known to the House.

An Leas-Cheann Comhairle: That concludes statements on the report of the expert group on the judgment in the A, B and C v. Ireland case.

Health (Pricing and Supply of Medical Goods) Bill 2012 [Seanad]: Second Stage (Resumed)

Question again proposed: "That the Bill be now read a Second Time".

An Leas-Cheann Comhairle: Deputy Sean Fleming was in possession but is not in the Chamber. I call Deputy Regina Doherty.

Deputy Regina Doherty: I propose to share time with Deputy Lawlor. This is a much easier topic for me to speak about than the last debate. I am grateful for the opportunity to speak. Many factors contributed to the health care spend in Ireland. Costs of technology, hospitalisations and hospital-based services, fees and drug costs are all major factors that drive the cost of care higher. To be effective, health care reform must address all aspects equally. Regulation and cost containment must be applied to each of these entities to lower cost successfully while maintaining superior quality of care. Across Europe, the pharmaceutical sector has been forced to reduce profits as governments go in search of savings on medical bills. Nothing like the rigour applied across Europe has been applied here, although prices have fallen since 2009. In the past decade, the cost to the State of drugs and medicines has risen to three times the Euro-

pean average, and pharmaceuticals in Ireland are among the most expensive in the world. Ireland has one of the highest spends on pharmaceuticals, with OECD data for 2009 showing that Ireland was fourth highest among OECD countries after the United States, Canada and Greece.

This legislation is one of a number of Government initiatives that aim to drive down the State's medicines bill. October 2012 saw the Irish Pharmaceutical Healthcare Association agree a new medicines supply agreement with the Department of Health and the HSE. The three-year agreement took effect from 1 November 2012 and will provide €400 million in savings. Under the agreement, when a patent on a medicine expires, its price to wholesalers will be reduced to 70% of the original price. After 12 months, the price will be further reduced to 50% of the original price. For existing patent-expired medicines, the price was reduced to 60% of the original price on 1 November, to be followed by a further reduction to 50% of the original price in November 2013. Recently, negotiations were also finalised with the Association of Pharmaceutical Manufacturers in Ireland, representing generic manufacturers, which heralds further significant savings. Added to this, a national task force on prescribing and dispensing has been established to deliver additional cost savings by achieving more cost-conscious prescribing. Due to become operational before the end of 2012, it will address prescribing and dispensing of medicines from the perspective of quality and patient safety and it will assess the suitability of maintaining supply of certain items with limited efficiency where more appropriate items are available.

In parallel with these changes, today's Bill is making its way through the legislative process. The Government envisages that, once enacted, the new legislation will reduce expenditure by increasing the rate of generic prescribing, which currently stands at approximately 18%. Against this backdrop, it is proposed that a system of generic substitution and reference pricing be established, allowing pharmacists to substitute a cheaper equivalent medicine when a more expensive product has been prescribed by a practitioner. Under the proposed reference pricing system, where two or more medicines are interchangeable, the State will reimburse only the reference price for the group of medicines. The reference price will be the price of the cheapest medicine in the group.

The Bill also provides for the regular review of the reference price for groups of interchangeable medicines and outlines the criteria to be considered by the HSE when setting or reviewing a reference price. What is new is the power the HSE will have to set or review the price of listed items. The Bill sets out the criteria to be taken into account by the HSE when considering the proposed price of an item. It allows the HSE to review and alter the price of items listed and to use a competitive process to determine that price. The Bill also allows the HSE to attach conditions to the supply or reimbursement of listed items in the interests of ensuring patient safety, improving cost effectiveness, maximising appropriate use of the items covered or appropriately applying the resources available to the HSE. The introduction of generic substitution and reference pricing has the potential to deliver significant savings for the State in the medium and long term. The Department of Health said it hopes to cut the drugs bill by another €50 million a year using generics.

I welcome reform and innovation in health care and the pharmaceutical industry in particular. However, it is also important not to lose focus on how such reforms will affect the needs of particular patients. I add my support to the amendment proposed by Brainwave, the Irish Epilepsy Association. Professor Norman Delanty, director of the epilepsy programme in Beaumont, has stated that anti-epilepsy medications cannot be substituted by a generic drug without having profound consequences for the well-being of those who suffer from epilepsy. The doses

of epilepsy medications are concentrated carefully for each individual to ensure good seizure control. Any variation may disturb the balance and result in an otherwise avoidable seizure, even if the active ingredient of the drug is not changed. This can have a major impact on the patient's quality of life, as well as having clinical and financial implications to the primary and-or secondary health care system. Anti-epileptic drugs should not be subject to generic substitution and should be permanently excluded from any legislation introduced in the country. Furthermore, the exclusion of anti-epileptic drugs from any new system of generic substitution was recommended in a report, entitled Proposed Model for Reference Pricing and Generic Substitution, and known as the Moran report, which was published jointly in May 2010 by the Department of Health and a HSE working group.

The campaign to exclude anti-epilepsy drugs from the Bill is supported by the entire epilepsy community and the health care professionals who treat and care for people with epilepsy. There is a model for this amendment as the United Kingdom, Austria, Belgium, the Czech Republic and Greece do not allow substitution of anti-epilepsy drugs for generics. Countries which have excluded many anti-epilepsy drugs from substitution include Denmark, Finland, Germany, Portugal, Spain, Sweden and Switzerland.

Over-spending on medications means the Government has less money to invest in other areas of health care. This legislation will have significant consequences for all stakeholders in the pharmaceutical supply chain. I am supportive of it but I appeal for the exclusion with regard to anti-epilepsy medication to be considered seriously. The patient must remain at the heart of our health care reforms.

Professor Charles Normand, professor of health policy and management at Trinity College Dublin, has contended that the economic crisis has provided the health service with an opportunity to restructure itself and that better services to patients can be delivered at a lower cost. Despite the enormous and continuing challenges facing the health services, particularly on the funding front, the Government's ongoing structural reform is well on its way to leading to a better service for patients. The transformation of our health care services calls for a change not only in what we do but also in how we do things, how we work together and how we commit to each other. By implementing the Bill as part of the reform programme, we can collectively bring about change that will fulfil our hopes and ambitions for health care services in Ireland. Building on the commitment and the success that has been delivered will take us to a position where we all feel proud of what we have achieved.

Deputy Anthony Lawlor: I welcome the Bill, which is a commitment by the Government to make radical changes to all sectors of society. Something like this makes savings and makes drugs more available to individuals.

12 o'clock

commend the Minister on his successful negotiations with the pharmaceutical industry, the medical profession and the pharmacists. Currently, we are spending €1,900 million per annum on drugs and we hope to save approximately €135 million per annum over the next three years. This is very welcome.

We need to explain to the public exactly what is meant by generic drugs. The vast majority of people who will avail of this new system might not know what is meant by a generic drug. It is important that we communicate this information. The interchangeable list will be key.

If an elderly person who has been used to a drug for a long period is told they can now use a new drug, it must be clearly explained that the new prescription is not for a different drug but for the same drug under a different name. For example, Ventolin and Airomir are both used in the treatment of asthma but they have the same active ingredient, which is salbutamol. When people know the key part of two drugs is the same, irrespective of the name of the drug, they will understand the system better.

The saving made by the new system is a key factor, but we must also be aware of the fear factor. A customer may be concerned if a pharmacist offers an alternative drug and may be worried that the drug being offered does not have the proper active ingredient or the correct percentage of the active ingredient. While the Bill, and the savings it will make, are welcome there must be a huge communication programme so people, particularly elderly people, are not confused when they are offered an alternative drug. Doctors must be involved in explaining this to patients. They have the trust of their patients. The involvement of doctors will make the scheme easier and more understandable.

The Minister can review the list regularly every three years or more often. This is important. New drugs are coming onto the market all the time. A new drug may be an improvement on an existing drug but may be more expensive because it is still under patent. We need to be able to put these new drugs, which will improve the health of patients, on the list more quickly than at present. I realise that will mean an additional cost, but if we can save money on one side we should use that saving to make improved drugs available more quickly.

I reiterate what Deputy Regina Doherty said about anti-epilepsy drugs. With other Deputies, I attended a talk given by Brainwave, the Irish epilepsy association. Minute changes in generic drugs can have a serious implication for people on long-term anti-epilepsy drugs. It is important that we take the fears of the association into consideration.

I welcome the hard work done by the Minister and his Department on the Bill. This is something we should have done a long time ago. There was a fear that if we did something like this the pharmaceutical companies would shut up shop and leave. Most of us understand that the major pharmaceutical companies are here largely because we have a low rate of corporation tax, a highly skilled workforce and a readily available natural resource. For those reasons, we should not fear the use of generic drugs.

I welcome the hard work done in preparing the Bill. The health service will get better value for money and we may be able to use the money saved in other areas in the future.

Deputy Finian McGrath: I thank you, a Leas-Cheann Comhairle, for the opportunity to speak on the Health (Pricing and Supply of Medical Goods) Bill 2012. This is an important Bill and it is also important to develop the debate on drugs, their cost and the efficient running of our health services. Because of the downturn in the economy the cost of drugs is now a huge issue, but efficiency and the cost of drugs to our health service should always have been an issue.

In dealing with the issue of pricing, we also need to ensure the safety of drugs. Safety must never be at issue in the supply of drugs, particularly by multinational companies.

This debate also gives us an opportunity to look closely at multinational drugs companies and their role in Irish society. They are an important aspect of the broader debate and of the debate on the Bill.

The pricing of drugs has emerged as a huge issue, but we must maintain a balance and consider the broader view of community life and the safety of patients. Recently, I was asked by a drugs company in the United Kingdom to lobby the Government regarding a new drug that will have a major impact on cystic fibrosis patients. I have gone to the Minister, made the details known to him and recommended the drug, which might have a major impact on 160 cystic fibrosis patients. The company claims this is a radical new drug that could save lives, and the Minister and the HSE appear to be open to this idea.

Sadly, the drug has a very high cost, but what is the cost of a human life? To supply the drug to a cystic fibrosis patient could cost between €200,000 and €400,000 per year, but it has huge potential to save the lives of these people. I have given the information and the name of the company to the Minister and to the HSE. I ask the Minister of State to look at the proposals regarding this new drug that has just been invented. It could have huge potential. We can deal with its cost at a later date. If it can save human lives we should get on with it. This issue also has important implications for the Bill.

The main objectives of the Bill are to promote competition between suppliers of interchangeable medicines and ensure value for money in the supply of medicines or other prescribed items to patients under section 59 of the Health Act 1970. The Bill will enable patients to opt for lower cost interchangeable generic medicines, establish a list of prescribed items that may be supplied or reimbursed by the HSE to patients under the GMS scheme and community drugs schemes, and establish mechanisms for setting the prices of these items where they are so supplied. No cost to the Exchequer will arise from the Bill and the introduction of generic substitution and reference pricing has the potential to deliver significant savings for the State over the medium to long term.

Cost saving is positive and sensible and we need to look seriously at it. We must also be careful to get the balance right. The pharmaceutical sector is a major employer in Ireland. A number of my colleagues referred to corporation tax. Yesterday in *The Sunday Business Post* I read an interview with David Gallagher, managing director of Pfizer Ireland. That company employs 4,000 people in this sector, a massive economic contribution to the State. I consider myself to be on the left but I agree with colleagues that the 12.5% corporation is the sensible approach. The Government, however, must be sure to get all of the 12.5% because there are all sorts of legal loopholes emerging and we must maximise the amount we get from these companies.

Mr. Gallagher, the managing director of Pfizer Ireland, said that the company is not a charity and that it invests where it believes it will get a return; it is as simple as that and there is no point pretending otherwise. That is straight talk from a man who has invested in Ireland to make money, and that is the bottom line. He has a good quality, highly trained and educated workforce with many graduates from Irish universities. When he says the company is not a charity, he is representing his vested interest. Our job as politicians, however, is broader; we must represent the broad, communal view. Our view must be different and must put patients and taxpayers first.

There is a conflict of interest but there is no reason we cannot deal with this issue. When Mr. Gallagher says Pfizer Ireland is not a charity, that is fair enough but we have a different philosophy. Mr. Gallagher was president of the Irish Pharmaceutical Healthcare Association until recently and he was strongly in favour of the pharmaceutical companies' lobbying of the Taoiseach earlier this year over a HSE decision not approve the new drug payment scheme. Many

people were concerned the big companies had more access to Ministers and the Taoiseach than the weaker and smaller groups in Irish society.

These groups must be around the table, I accept that, they provide jobs to Irish people and pay corporation tax, but I worry we might be losing the balance in the debate about the respite care grant. We all jumped up and down about the grant in the past week but the €26 million cut was made to the respite grant anyway. The Minister and many people on the backbenches are privately very unhappy about this but they must face the reality. Are the carers less effective than multinational companies? They did not get a fair crack of the whip, which was the Labour Party's role in Government. That is not a rant, it is a reality. Even at this stage, in the next 24 hours, I ask the Government to revisit the respite care grant. If we are talking about equality, people with disabilities and carers, and building a new, inclusive republic, we should have the courage to say we got the respite care grant issue wrong and should change it. It is never too late and there is nothing about which to be ashamed. I want to represent those with a disability and the carers, and I will keep pushing that issue.

The figures for expenditure on medicines and no-drug items are huge. In 2011, the HSE expenditure on medicines and non-drug items such as dressings supplied to patients in the community was approximately €1.9 billion, including mark-ups and dispensing fees paid to pharmacists and wholesalers. In addition, hospital expenditure was €300 million. The HSE expenditure on medicines and non-drug items supplied to patients in the community has decreased in recent years from €2.01 billion in 2009 to €1.91 billion in 2010. In 2011, the figure had fallen to €1.9 billion. This is in contrast to an increase of 185% between 2000 and 2010. The number of items paid for by the HSE under community schemes increased by approximately €30 million in 2000 to €70 million in 2010. Those are the figures about which we are talking.

Savings have been achieved through the ongoing off-patent price cuts agreed with the pharmaceutical manufacturers and we welcome that. The Department and the HSE continue to engage with the Irish Pharmaceutical Health Care Association and the Association of Pharmaceutical Manufacturers in Ireland to secure reductions in the price of drugs. In July 2012, an agreement was reached with the IPHA on the interim drug price reductions, which will deliver further savings of €20 million in the price of off-patent medicines. These price cuts were accepted by the Minister for Health in advance of further discussions with the IPHA, which are expected to deliver more significant savings. Negotiations are ongoing between officials of the Department and the HSE and the IPHA since in the interim agreement was reached. I expect these discussions to conclude shortly. I welcome that €20 million reduction because it is close to the €26 million that is being cut from the respite care grant. There have been savings and reductions but we must also ensure the reductions and savings are sensible.

In July 2009, the wholesale mark-up paid on medicines was reduced from 17.66% to 10%, a sliding dispensing fee was introduced and the retail mark-up paid under the drug payment scheme. The long-term illness scheme was reduced from 50% to 20%. These changes result in annual savings of €120 million. That is sensible and we can up our game here when it comes to efficiency.

In June 2011, regulations were made to reduce certain payments by the HSE to the community pharmacy contractors, which included a reduction from 10% to 8% in the wholesale price mark-up of drugs items. There was a reduction from 17.66% to 8% in the wholesale mark-up of controlled drugs and a reduction from 17.66% to 12% in the wholesale mark-up on items. Also, there was a reduction from €62.03 to €31.02 in the high tech non-dispensing fee which

led to savings in the region of €34 million. I use those figures because when the negotiations took place with the IPHA, there were reductions of €30 million and €34 million in two sections. Once again, I remind the House the respite care grant cut was €26 million. There are options on the table.

The reaction of the IMO to this legislation is important. It has stated it welcomes the proposals for reference pricing but would not include the maximum potential saving on its own. It stated it does not believe pharmaceutical substitution is the most effective mechanism to support reference pricing and generic consumption. Policies are required to encourage all parties, including patients, doctors and carers, and not just pharmacists to promote the use of generics. There is a potential risk to patients because receiving different medication each time they are given a prescription by pharmacists could lead to non-compliance. In addition the Irish Medical Organisation, IMO, has suggested that current policies for setting generic prices are not optimal and it has argued for the promotion of more competition as a means of achieving price reduction. It is important when an important stakeholder such as the IMO is on the pitch to listen to its contribution and recommendations and I urge the Government to consider them. The organisation has good recommendations for a generic policy, including, for example, reducing the cost of generic medicines by ending pricing agreements for off-patent and generic pharmaceuticals and promoting managed competition.

The organisation has called for the Irish Medicines Board to ensure regulation does not unduly discourage the entry of safe generic medicines to the market. This is something I referred to earlier with regard to safety. I always tend towards the Irish Medicines Board because it is important. Safety should be an issue as well. IMO initiatives to encourage the manufacture of generics in Ireland should be explored. It has recommended a system of pharmaceutical reference pricing for off-patent generic medicines.

The IMO also proposes transparency in the distribution chain and has called for the regulation of margins. It has highlighted several important and relevant aspects of the legislation and the need to introduce a public awareness campaign to inform the public of the advantages of generic medicines and to alleviate any concerns. That is important. When it comes to the broader issue in the debate, one of the IMO recommendations is to carry out a cost benefit analysis to compare newer and what are frequently more costly options. Basically, these are the views of the IMO and because it is a major stakeholder, it is important to consider them.

The Irish Pharmacy Union, IPU, is the representative organisation for community pharmacists in Ireland. It has broadly welcomed the plans to enable pharmacists to dispense cheaper generic drugs and it has broadly welcomed the legislation. As with other stakeholders, the IPU has not commented on the specific provisions in the Bill to date. It has stated that generic substitution is standard practice in many other countries and it would mean lower medicine prices for patients as well as considerable savings for the State. It believes generic substitution should be introduced without delay. The IPU is on board in this regard. However, in the case of the introduction of reference pricing, the IPU has advocated a cautious approach. It has recommended that reference pricing is a highly complicated mechanism and does not represent a quick fix. It believes careful consideration and engagement with key stakeholders is required to ensure there is no disruption of supply. It believes the impact of reference pricing on patients and pharmacists rather depends on the model of reference pricing introduced. In some countries reference pricing has led to a shortage of certain medicines. It is important when there is a group such as the IPU on the pitch to ensure we listen to its views.

The final group which we must consider is made up of patients groups and patient advocate groups. Their concerns have centred on the question of whether medicines are genuinely interchangeable for particular conditions. Several advocacy groups have requested that certain medicines be exempted from substitution. For example, the Irish Osteoporosis Society presentation to the Joint Committee on Health and Children recommended that certain medicines be exempt from substitution. My colleague referred to the Irish Epilepsy Association. It has argued that the substitution of branded epilepsy medicines with generic equivalents or switching from one generic to another generic version of the same drug can lead to a recurrence of seizures in some people whose epilepsy is otherwise under control. As part of the debate on cost saving we should take a broader view and I acknowledge the Government is doing so. One should listen to different vested interest groups. However, as someone who will promote patient issues, I am strongly supportive of the Irish Epilepsy Association and its arguments.

I welcome the broader debate. We all seek efficiency and cost savings on drugs in the State because it is a significant issue. I noted earlier in my introduction that it was important to get the balance right. There is a major contribution from multinational pharmaceuticals companies in the country. We want to hold on to them because they employ Irish graduates, staff and workers. They make a considerable contribution, but one cannot come to the table with too much clout. If one believes in equality, one must believe in fair play, and I am concerned about some of the industry's excessive clout at times, especially at the expense of more vulnerable groups in Irish society. I welcome the debate and I thank the Leas-Cheann Comhairle for this opportunity.

Deputy Damien English: I welcome the opportunity to contribute to the debate on the Health (Pricing and Supply of Medical Goods) Bill 2012. It is unusual to be in the House on a Monday and it is good to get a chance to speak on this issue, among others. The Bill is another important part of a practical tranche of legislation which has come through the House lately. It will deliver greater reform and competition for the broader health sector. The Bill seeks to ensure value for money for the taxpayer and the consumer on a revenue-neutral basis. It is important to note, at a time of great public and media cynicism about politics and the work of this House, that the Bill answers the commitment given in the Fine Gael and Labour Party programme for Government to reduce the State's large drugs bill and to reduce the cost to individuals of medicine. The commitment was that this would be achieved through reference pricing and greater use of generics.

It is important to address not only the cost of medicines to the consumer but the cost to our health services of the purchase and supply of drugs. There has been a difficulty this year in getting reductions quickly and in securing the deals to prevent some of the necessary cuts or adjustments in the budget of the health service at the end of the year. It is a pity this has occurred but, ultimately, these things are delicate, they take time and they must be done right. We must ensure we are in a position for next year's health service budget - I believe we will be - to take advantage of the commitments and the deals that have been done this year. We would rather they had been done earlier. They should have been done years ago but they were not. At least the reforms are happening now and it is about time we benefitted from them.

I have no doubt that under the parties in government we will get great reform of the health service. However, that reform cannot happen overnight, in one week or in two years. It will take the full four or five year term of the Government and possibly one or two years into our second term in government. We must keep on with the fight to fix the health service. This Bill, along with other discussions held in recent months, is part of the reform.

In the short term, things will be difficult. In the past one or two months we have seen cuts to home help and home care packages and so on. In some cases there are areas where one can make changes without affecting others, but in other areas it is not possible and services are hit. This is because, in the short term, when one is trying to root out problem areas and the mismanagement and misspending that has taken place over the years, it takes time to find all the areas where money is going to waste. However, we must do this to reduce the negative effects on the front line and those who need it most. This is what we are trying to do. We are trying to find areas where we can save money in order that we can protect those on the front line. No one wants to see any reductions to home care packages or home help. I accept the Ministers involved are trying to bring in new ways of doing this to ensure those who need it most are getting the services.

I hope the reforms are introduced and bring about better management of resources on a 12 month basis rather than nine months and a crash course at the end to make savings. We should get a spread of change more easily because if one only makes budget savings in the last two months, inevitably one goes to the quick fix areas where one can save cash. It is as simple as that. I worked in the accounts area of the health service and I know what happens. To save money, sometimes it is easy to go to the areas where one can save cash quickly. These are easily identified but often they are the areas of greatest importance. There is no choice if we leave it until the last minute. We must manage the health budgets over a 12 month period and this involves every level of management and every worker in the health service doing their bit as well as the Ministers at the top. There must be a joint effort across the board. I speak to staff on a daily basis who can identify areas of waste. These staff should be allowed to speak up and must be listened to in order to bring about these changes. I have no doubt that we can save money in the health services without affecting services but we need everyone to come together to have that conversation and to find these areas. We need to be able to bring in the reductions without hurting the front line.

I have spoken about what happened in the health service budget. I have consistently said it was the greatest failure of previous Administrations. They were in power over ten or 15 years and involved several parties, but mainly Fianna Fáil with Bertie Ahern at the top for almost ten or 15 years. At that time budgets in every Department were left to go mad, as it were. There is no other way of putting it. The health budget is as clear an example as one can get. In 1997, the health budget was about €3 billion. In 2007, it was €15 billion, which is crazy. The number of people working in the health service went from 70,000 to 140,000. I recall a debate in the House on the health service in 2006 or 2007. On the same day, the Taoiseach, the Tánaiste and a Minister were asked how many people worked in the health service. I forget which of them said what but one of them, who could have been the Taoiseach, said in the morning that 110,000 people worked in the health service. In the afternoon, the then Tánaiste, Mary Harney, said that 120,000 people worked in the health service. Later on, the then Minister for Finance, Brian Cowen, said the answer was 135,000. This shows that they did not have a clue about how many people were working in the health service. It is not that difficult to count 110,000 or 120,000 people. I know some of them are equivalent or work half or quarter time, but it is still no harm to count them. If one were the head of IBM or Intel, one would know how many worked for the company.

Thankfully, we are now getting a handle on our health service and know how many are on waiting lists, including outpatient waiting lists. One must count the problem before one can fix it. It takes guts for Ministers to announce how many people are waiting for an operation but

that they are going to tackle the matter. It takes guts to admit that there are 350,000 people on the outpatient waiting list but that we will tackle it. I spoke many times while in opposition about how one must first admit one has a problem and then one can put a plan in place to fix it. That is what we are trying to do here in many areas. Great progress has been made in respect of health service reform, but it will take time. Before they entered Government, both parties always said it would take over five years to fix the health service completely, and we will fix it.

Two excellent reforms are the concept of money following the patient and increasing capacity in some of our units. The orthopaedic unit at Our Lady's Hospital in Navan is carrying out great work and is way ahead of targets set out for the year under the new concept of money following the patient. When we bring in these reforms that increase our capacity to deliver, the State must be able to benefit from the reforms. Sometimes, because of cash budgeting and a shortage of money, capacity has built up towards the end of the year in a certain unit, be it an orthopaedic or elective surgery unit, that could be used, but because of the additional cost of buying the equipment needed for the operations, things might not happen. When we introduce reforms, we need to ensure we can somehow find the extra cash to use the asset. If one has a theatre and staff who are ahead of capacity and ready to do more work, we must find the additional resources we need for that unit to do the extra work although I know this takes time. It might be a case of doing more private work through a deal with some of the private health insurance companies. I know this is on the Minister's mind. If capacity has built up in State-owned assets, we must be able to use it as best we can. All the reforms in the world will save us money in the long term and enable us to work much better, but we need imagination as we journey towards major reform.

It is interesting to note that during the dreaded years between 2001 and 2008, spending went wild. There was an increase of 185% in HSE expenditure on medicines and non-drug items, with the figure reaching €2 billion in 2009 and falling back to €1.9 billion last year. At the same time, the number of items paid for by the HSE on the community scheme increased from 13 million in 2000 to 17 million in 2010. No one would dispute that it is important that people who are sick get the necessary treatment, but it is very debatable as to whether the level of sickness in Ireland rose 185% in ten years, even when one factors in a rising population and the stresses and strains of the Celtic tiger era. I know there were significant improvements in drugs and treatments but it is not right that the cost rose by 185%. There was clear price inflation, bad deals and a lack of regulation and oversight in this sector, which this Bill will provide a legal framework for dealing with.

I stand behind the Minister and his team in any reform to put value for money for the patient and taxpayer ahead of bloated and outdated systems. As a public representative for Meath West, I am deeply aware of the price of medicines and the ability of hard-pressed families to deal with this necessary living cost, and I am sure the same can be said for all my colleagues in this House and local authority members. It is something that none of us as public representatives can escape. We know all about it through the people we represent, and it is an area we must tackle.

Greater access to the Internet and more shopping outlets and chains north and south of the Border, as the desire to shop around for value for money has grown, have led to greater public awareness of the price of medicines. In some cases, this greater awareness turns to despair and frustration as there can be large disparities in the price of certain drugs between individual suppliers in this State and, more dramatically, between this State and Northern Ireland and other parts of the EU. This is before we factor in the use of generic drugs. While we all desire to shop

as locally as possible, especially at this festive time, and to support our own neighbours and maintain local employment, facts such as those I have just mentioned present a serious challenge to this mantra. Some families do not have a choice. Their disposable income is so low that they have no choice but to travel to spend their money, even though they know it is probably not good for their community. If someone is travelling to Northern Ireland to purchase cheaper medicines, he or she may decide to make many other purchases there. These are the challenges presented by the existence of two jurisdictions on this island and our membership of the EU where price comparisons with the euro are much easier.

The role of Government is to rise to and meet this challenge for the good of the consumer. Pricing and affordability, especially in these more stretched times, should not be allowed to put people's health in jeopardy. As a Deputy meeting constituents, I have plenty of evidence that this is a stark and sad choice facing many. Problems and delays in processing medical cards and GP-only cards add to a sense of stress and worry which also impacts negatively on people's physical and mental health. Today's article in the *Irish Independent* touches on this area. It is only when one reads the article that one sees what the problem is. When one reads the headline, one thinks that everyone will be hit for the extra daily charge of €75, but that is not the case. It again identifies the problem we are trying to fix in Government. It is those who do not get a medical card, cannot afford health insurance or have had to let their health insurance lapse who are affected. It is the people left in the middle who must fork out for this daily charge of €75. It is not just for chemotherapy or other cancer treatment, rather it is for any treatment for which one has to go into hospital.

The charge was not always pursued. This is a sign of more mismanagement because, in times gone by, people could have afforded to pay that charge and there are probably many who can still afford to pay it but, instead, put their heads down and hide and let those who cannot afford to pay get hit the same way. The article states that hospitals are engaging debt collectors, a development I do not like and with which I must regularly deal on behalf of people. That should not be necessary because there are quite a few people who could pay their bills but will duck and dive and hide. One then ends up with people who do not have much money being pursued because everybody gets pursued, which is unfair and wrong. The same can be said for all our services. We as Deputies work to help people who fall between the red lines to access services, and we come across many people who get those services but do not necessarily need them. That is the way it is in this country, because so often people who need things cannot get them because of procedures we put in place to protect them from abuse.

The article in the *Irish independent* dealt with cancer sufferers undergoing the most traumatic time of their lives. Dealing with medical card procedures can lead to the build-up of considerable stress and we must solve the problems associated with them. I accept the system was centralised and that there are many staff trying to work through this under immensely tough conditions. However, there are systematic failures in how we deal with this. I know the volumes of medical and GP-only cards have increased by hundreds of thousands but we must look at this system to ensure those facing severe physical and mental threats, for example, those dealing with cancer, get priority and a decision. I know staff probably do their best and sometimes one sees priority being given, but we need a system-wide approach in order that it becomes the norm that those most in need get it. People are under enough pressure as it is. Due to the increased numbers of medical cards, the ability to apply common sense has probably been taken away and members of staff must follow rules and regulations to the letter of the law, but some people then fall between the cracks. We need to apply common sense in the same way the

system worked years ago with the community welfare officer where short-term medical cards lasting three or six months could be given out. We must address this problem because people are under so much pressure.

The newspaper article also mentions volunteer drivers and how cancer sufferers require more heating in their homes. I am very familiar with the work volunteer drivers do with people suffering from various medical conditions, chiefly cancer. They bring people to their treatments every day or three or four days per week. These people, who do great work in all counties, must be thanked. Sometimes they do this work at great expense to themselves. In some cases, they do this work along with the Flexibus and community transport schemes in our towns. In my constituency, Meath Flexibus does great work along with the volunteers in co-ordinating and matching that and bringing people to some of those services. They must be thanked. They were going to address the problems of the health service, which needs everybody to put their shoulders to the wheel with ideas, imagination, cost solutions, support and help. While medical cards are very important they are costly items from the perspective of the State and we must target them as quickly, efficiently and fairly as possible at those most in need. It happens in some Departments that material goes missing or information does not arrive in time or gets stuck in the post. We can no longer allow this to happen. We must be able to deal efficiently with matters. It is not good enough to have to ask for information a second time, particularly if the people involved are dealing with difficult circumstances.

In recent years there has been much talk of generic drugs. Consumers are becoming more aware they are a low-cost option. This will not always suit drugs companies which are naturally profit driven but, it must be said, they also re-invest some of this profit into research and development, most of which benefits the domestic Irish economy. The Bill must strike a fair balance. I listened to recent debate and comment about who the Taoiseach does and does not meet. From what I can see he is open to meeting all groups. The pharmaceutical sector employs more than 29,000 people in the country and we must recognise this. Companies spend a fortune to bring a drug to the market and we must understand this in our debates. However, in some cases we pay a disproportionate amount compared to other countries and we must correct this. Let us not forget what the companies spend to bring a drug to market. Many other drugs may not get to market and this involves great losses.

The safety of generic drugs has often been questioned but I suggest that at times this has been for negative public relations reasons. The debate has moved on from this but the suggestion still lingers among some members of the public. This is why the Bill requires that all generic medicines on the Irish market be fully licensed and compliant with the standards set out by the Irish Medicines Board. There will be cases where allowing a generic drug to be interchangeable on a prescription will not be appropriate and the Bill allows for this. I trust it will be used sparingly and for the right reasons.

The recent Trinity College Dublin Irish Longitudinal Study on Ageing, TILDA, of adults over 50 is timely and worth mentioning in this debate. It highlights how many older people take combinations of often very costly drugs to help with the fact that as we age we accumulate more health problems and even severe chronic pain. According to the TILDA report, on average those over 50 take two medications per day, those over 65 take three per day and those over 75 take four medications per day. The report also states there is much risk of duplication, inappropriate prescribing or overprescribing and we must watch this and deal with it. I have dealt with clients in my office of a much younger age who arrive in with various health problems, sometimes physical and other times mental, with a bag of prescription drugs which they have

been given over the years.

More than half the annual cost of prescribing drugs is accounted for by those aged over 50 years. The TILDA report highlights that greater use of generic medicines by this sector of the population could save upwards of €150 million a year. However, it also highlights price surges in the Irish market even for generic drugs when compared to the UK. Seven of the top ten generic drugs are more expensive here than in the UK with two being almost six times more expensive. While generic drugs are a much-needed help, this situation requires careful monitoring and tough questions should be put to the industry, particularly in light of price reductions agreed in 2010 and 2011.

If we are to adopt a medium to long-term view of the health sector in Ireland, and the Government has done so, as well as dealing with the day-to-day issues, we must return again to the concept of health screening and promoting better health rather than just treating and managing illness and pain. The Minister of State, Deputy Alex White, and the Minister for Health want to tackle this through the primary care strategy and dealing with preventative medicine. People's health should be managed as close to their homes as possible. This goes back to everybody in the community getting involved and not only leaving it to the State to help out. Everyone has a duty to help out their families where they can and the State steps in where people cannot do so.

The HSE and health insurance companies could tackle long-term costs with a greater focus on health screening and early diagnosis. It costs relatively little to identify and warn somebody of their risk of type 2 diabetes or the consequences of not managing their blood pressure and to urge cheap lifestyle changes through diet and exercise patterns compared to the cost of dealing with impaired vision, amputation, heart attack or stroke for the same person in 20 or 30 years time. We see a great demonstration of this in the television programme "Operation Transformation". It is a great programme and would be of help to us all with our health. It shows how easy it is to get a hold of the issue and tackle it at an early stage. It is about advice and education. The Minister and Ministers of State at the Department have been involved in these programmes and other similar programmes.

This is clearly in the public good in terms of quality-of-life and making better use of taxpayers money, but it requires a shift in our thinking as individuals and as a society. This may sound like political aspiration but with political will it can become political reality and would change the goalposts for the health debate in the Dáil for many of our children or grandchildren who will aspire to serve here.

Earlier I referred to the greater awareness the Internet brings to the cost of medication and the choices available. However it also brings with it many dangers. A huge increase has taken place in the number of people buying medicines and medical products over the Internet and this is a serious health issue. The Oireachtas Joint Committee on Jobs, Enterprise and Innovation has begun to look into the black market and the illicit trading of goods. Part of this has involved examining the illicit trading of medicines and the purchasing medicine on the Internet. A regional meeting with the Irish Pharmacy Union raised many issues of concern. It is a major problem and we must realise counterfeit medicines are too easily available. We have much to do to protect people and warn them of the health risks involved. Many of these products are fake and no good to anybody. We have many issues to tackle and the committee hopes to bring forward solutions to a range of Ministers to address them. They include cost and small changes that could be made to the taxation code or with regard to information. However, education is the key. People must realise illicit trade is not victimless. It can have health implications but

can also cost jobs. We must tackle the issue.

Deputy Catherine Murphy: This legislation has two aims. The first is to change reference pricing. We all realise we adhere to a very narrow band and if we were to reference against the other 26 EU member states it would considerably reduce the cost of drugs. The second aim is to allow for a greater use of generic drugs instead of branded drugs. I take the point made that generic drugs would not exist if it was not for the development that goes into branded drugs in the first instance but this is protected by patents for a specific period of time to cover the development.

The object of the exercise should be to free up money which can be spent in the health service, particularly in delivering primary health care or front-line services. However, exceptions should be made for some areas such as anti-epileptic drugs. There can be a very fine balance for somebody with epilepsy in remaining free of seizures and to upset this could be very problematic. In 2010 we passed legislation relating to an EU directive on the length of time people must be seizure free before they are allowed to drive. Included in this legislation are rules and regulations on changing medication. If one goes off one's medication one must be instructed not to drive for perhaps six months. If one receives different medication it could produce breakthrough seizures where the previous medication used had been keeping someone free of seizures.

It is very important that an amendment is made to provide specifically for this. Often people do not return to a consultant or see a neurologist but instead they are maintained on their medication by their GP, who may not realise he or she cannot substitute. Failure to address this aspect could cause individual problems, and serious problems could also be caused for those using machinery, or people may have falls and present at accident and emergency departments.

The other point relates to those who are on drugs that suppress seizures. Sometimes these drugs can have other side effects where it is a matter of finding the right drug and finding the right balance. There might be a 10% tolerance in finding exactly the right balance and to upset that balance will be very problematic for potentially 40,000 people who are doing well. For example, the changes that occurred for those with epilepsy in the past 30 or 40 years have been immense. It has been a good news story for so many because it has given them back their independence. It has made them feel confident again because they can have some control over their lives. Often epilepsy takes away that control at key times in a person's life, for example, when one is a teenager and has so much else going on. Recently, I was dealing with somebody where a youngster got a poor leaving certificate because she had epilepsy in that year, was going into college, was maintained on the drug and was doing well. We will spend a great deal putting that youngster through college but one wants her to go through at the best of her ability, and it is important to have her epilepsy controlled.

I cannot stress enough the importance of there being provisions in the Bill that allow for specific conditions such as epilepsy - I am sure it is not the only one. Such conditions will be the exception. Generics can contain very much the same ingredients and work well with most conditions, but conditions such as epilepsy are different. There are other countries that make exceptions when using generic drugs. Denmark, Germany, Portugal, Spain, Sweden and Switzerland all exempt epilepsy. Where there has been good reason to deviate, it makes for good health policy to do that.

One of the most expensive elements of producing drugs, which we cannot address in this

legislation but which might be something that we can advance at the European Union, is packaging and the various individual sets of instructions. Clearly, there are language difficulties in the European Union. Having said that, there are significant variations in the health regimes in the various EU countries. That is costing significantly more than it needs and it is something that should be picked up at some point through the appropriate Commissioner in the European Union. It is important to point out that the variations involve a needless cost. Then there are some countries, such as Ireland and the United Kingdom, which do not have a difficulty with language, yet something that is sold in Northern Ireland could not be sold over the counter here because it has an entirely different set of instructions. One might not be able to do it for all of the countries but one might be able to provide for elements of uniformity in countries that would be similar in terms of language. This would be another way of cutting costs.

One of the big savings that was hoped for this year in the health service that did not materialise was the reduction in the cost of drugs. Some of that was to do with the basket of countries against which we price ourselves. Clearly, this legislation will provide for that for next year. It is important that we are not wasteful. Invariably, when people who are abroad on holiday and become ill or suffer from asthma, they can buy drugs over the counter which are only available on prescription here, and the variation in price is astonishing. Not only will this potentially save the State a great deal of money but it will save individuals, who are just on the margins of availing of a medical card, a great deal also. It is really important that we ensure that people retain money in their pockets if at all possible, particularly at this difficult time.

I want to raise a matter that is on the fringe of this. There is a need to have a health system that is about health, not about illness. Until we have a decent primary health care system, we will not have that. There are patients turning up very late for diagnosis and if there was a decent primary health care system we would save money and keep people healthier. Too much of what has happened is the result of the notion of measuring health in terms of the number of patients who are no longer on hospital trolleys or who are able to get procedures in the acute system. It saves a great deal if conditions, such as diabetes, are diagnosed and treated much earlier. We cannot get to a point quick enough where there is a decent primary health care system because we all will benefit from that.

There have been newspaper reports of cancer patients having to pay for their medications. That is not new. I recall a family member having to do it five or six years ago, and it took me completely by surprise. It seemed to be one of the few situations where a person turns up in a crisis, as one does when one has been diagnosed with cancer and is possibly only over a major operation, and then goes on to chemotherapy only to be handed a bill of €56, €70 or whatever. In some cases, one would question whether the person has such sums in their pocket. It seems strange. In most circumstances, that would not apply. I have never understood why it applies in the case of cancer. However, it is not a particularly new departure. I would like to hear a response as to why it happens in the first instance.

Deputy Bernard J. Durkan: I am glad of the opportunity to speak on this Bill. It has been a long time coming. It was a commitment made by the Government parties when in opposition and was part of the programme for Government. We hope that the Bill, like all of the other Bills on which we speak in this House, will achieve its purpose, which is an important aspect of any legislation.

We all are faced with a difficult time in spending in this country. Cost cuts must take place in respect of almost every service. It is a tragic position to be in but that is the way it is. The

suggestion put forward in some quarters that some cuts are painless and that others can be diverted to other areas is not the luxury that people can readily live with. In all budgetary situations, cost savings and cost cuts are measures that hurt everybody. Whether in full health or ill, there is an impact. In some cases we can do nothing about it other than to try to make the best provision we can to deal with the situation even in the face of such a budgetary situation.

My colleague, Deputy English, referred to an issue I can never understand.

1 o'clock

In a previous incarnation I spent a long number of years in a health board where we experienced a similar situation. There were always cuts coming from July onwards and more particularly from October to Christmas. That happened because there was not an ongoing evaluation of spending, which could have been done very simply. Every budget relates to 365 days a year. One can divide the budget by 52 weeks or 12 months, but either way it comes down to the same thing - it is possible to identify where the problems arise most and, consequently, what needs to be adjusted and changed within any departmental budget at any time. It is not something that works easily, however, because every departmental section, particularly in the health services, competes to avoid cutbacks. In the current situation, however, we do not have the luxury of avoiding cuts. I therefore ask the Minister and the Minister of State, Deputy Alex White, to ensure that henceforth the budget will be evaluated monthly at least. It is possible to input all the untouchables and unmentionables, in addition to - as a former American Secretary of State for Defence put it - the known unknowns and the unknown unknowns. I do not wish to go too far down that road, however. There are issues, within the health services in particular, that we know about and therefore it is possible to introduce economies that will benefit service delivery across the board.

I also wish to mention the prescription of generic drugs. I remember having an arduous and long drawn out debate as to the merits of reducing medical costs that could be derived from prescribing generic drugs. I also remember a long input from some Members on the opposite side of the House opposing that concept. A heated debate took place and eventually in one of the biggest health boards in the country it was possible, through block procurements and generic prescribing, to bring about substantial reductions in the cost of medicines across the board. It took a great deal of agitation to achieve that but it did happen. There was regard for the areas where brand name drugs were better known or deemed to be better for patients in certain conditions, and that was even allowed for.

We also found that the brand name drugs companies were able to compete effectively with the generics in many areas despite notions to the contrary. As regards the supply of goods and services, including drugs, and the delivery of health services in general, it is in the interests of all such patients to get the best possible value for money. We must use all the means that have proved effective in the past, without putting patient safety at risk. I believe that can be done.

One must also have regard to those suffering from cancer and other serious illnesses, as Deputy Catherine Murphy said earlier. This is not a new measure; it has been there previously, but in some cases it was not enforced. There is no good time for re-introducing legislation that was not enforced in the past. There is no reason either why it should be introduced selectively, but due regard must always be had for the severity of the illness faced by patients and their vulnerability. In that way, we can ensure that we do not become a careless society instead of a caring one. It is well within the remit of the health services to adjudicate between the various

categories in terms of severity and need.

I am not a follower of the concept of centralisation when it comes to determining eligibility for medical cards. It is much easier to do so at a local level and was so in the past. There will be those who may say that it was more expensive, but it was a lot more personal. People at local level knew exactly the nature of the application and very often knew well who the patients were. In those circumstances, it was much more possible to be able to introduce relevant information that would clearly indicate whether or not the patient needed a more flexible and accommodating attitude. I am not saying for one moment that the current system is inflexible or uncaring. However, by virtue of the volume of correspondence and inquiries going into that department, it will naturally follow that the same degree of personal adjudication is not available.

Another area that warrants examination - I know it will come within the ambit of this Bill - is the supply of special clothing, footwear, wheelchairs and other appliances through the health services to individual patients. Like other Members of this House, I have received complaints from people who have appliances they no longer require. For whatever reason, such appliances are not collected or recycled for re-use in the system. Since such appliances are not available for other patients, the latter must await a further allocation of scarce resources. As a cost-saving measure, it should be possible to return appliances that are no longer required by certain patients. It happens in other jurisdictions all the time, so we should be able to do it here, particularly at the present time. I hope it will happen.

I am aware that a brokerage system exists concerning the supply of goods and services to the health service. The broker, for want of a better description, supplies a variety of goods and services, sourcing those products in various ways. Many of them emanate from outside this jurisdiction. Very often, however, a loss leader is used - in the same way that supermarkets use alcohol - in order to reduce the overall cost of the package and thus get more of the product from a particularly friendly source. That practice needs to be discontinued. I have tabled parliamentary questions about it in the past but the practice has gone on for many years. It is particularly difficult to challenge when costs are being reduced generally because the argument will always be made: we're reducing costs and this is how we have done it and it has been of benefit to the Exchequer. That is not necessarily the case because there can be hidden costs as well. I know the Minister is fully aware of this matter but I would like to see it being addressed. We must try to ensure that we source as much material and products as we can from indigenous sources, notwithstanding domestic and EU competition laws. We currently have our backs to the wall in terms of costs.

A great many sacrifices have been made by a great number of people and Members should try to ensure that those providing the services, whether directly or through agencies, are also subject to the same cost-cutting and saving exercises applied to patients and everyone else.

In response to the points made by various people in comparing carers with pharmaceutical companies, drugs companies and so on, while I acknowledge it is natural to do this, one must separate the two. Everyone in this country is a caring and compassionate person. Traditionally, as a race, we have shown this over many years. No one, either in government or outside it, goes out to make life more difficult for anyone. The suggestion coming from some Members on the Opposition side in recent weeks that the Government comprises a careless and heartless group of people who are imposing punitive measures on top of a luckless and hapless public is not true. Moreover, for those who keep repeating there are always options and alternatives, the alternatives put forward by the Opposition invariably are easy options that apparently do not

have an impact on any of their constituents. While they give the impression to the public that such alternatives are painless and somehow will be washed away with the next shower of rain or whatever the case may be, nothing could be further from the truth. There are no cost-cutting exercises without pain and there are no budgetary constraints that do not cause concern to a great number of people or that do not affect many people in a negative way. Any Government cannot but be fully aware of this. Moreover, no one can give Government members lectures on caring and compassion and no one should try to do so. The suggestion in some quarters that all the care and compassion is on the opposite side of the House is rubbish and they know this.

A number of speakers have mentioned the issue of promoting health awareness as being of particular direct benefit to the Exchequer. I had an experience in this respect a couple of years ago in which a friend was accidentally diagnosed - that is the only way to describe it - by a passing physician. I refer to an encounter at a crowded reception, when the person concerned was quizzed by the medic as to when the person's blood pressure has been checked. This is the difference between a highly observant person and someone who may not be so observant. The would-be patient replied it would be checked at the weekend, only to be told that would not be sufficient. The person concerned then stated it would be done at the end of the day, only to be told that would not be sufficient either. Eventually, my friend's blood pressure was checked within the hour and the results were alarming. I use this analogy to illustrate one's lack of awareness of, for instance, the tell-tale signs of blood pressure that requires monitoring or kidney failure, which are of huge importance, as well as a range of cardiovascular illnesses that must be monitored on a regular basis. There are ways and means to do so effectively at an early stage if one is alert to them. In the same way, the health issues and concerns of young people must also be addressed on a more regularised basis than has been the case in the past. In particular, efforts should be made to try to ensure that young people do not get overly concerned about, for instance, the need for weight loss or the lack of need for weight loss or whatever the case may be. However, this should be done in a balanced way and knowledge should be imparted in such a way that is supportive of whatever is required and where those concerned will feel they have support as opposed to criticism and thereby will be in a position to deal with the issues.

Other points have been made with regard to patients who suffer from cancer, for example, although the same is true of any serious illness. There used to be a tradition whereby a medical card automatically was made available for all patients who suffered from cancer. Some time ago, I heard a debate among some medical people, ironically, in which it was suggested perhaps one should wait to ascertain whether a serious form of cancer was involved. However, I do not believe this to be the issue. The impact on a patient who is greeted, for want of a better description, with the prospect of an illness of that nature is so great that one should try to give whatever support is possible and necessary in the shortest possible space of time. Moreover, the question of the cost to the patient should not arise at that stage in particular. The danger of creating further stress and concern for the patient at that time is counter-productive to all concerned and can do no good to anyone. Consequently, I ask that the discretion the health services have with regard to such matters should be used carefully to try to ensure it is acknowledged to patients who are sufferers of serious illnesses that there is a problem. It should be made known to them that it is realised they require immediate support for their particular problems, and not next week or next year and not awaiting the outcome of a debate in some other location at some time in the future. Clear time and energy must be devoted to this issue.

Earlier, I mentioned the issue of generic drugs versus drugs with brand names. In particular,

I again emphasise that no one seeks to create a risk for patients. In the use of generics, it must be both possible and shown clearly that the patient being encouraged to use generics will have at least as good a product as the one that is brand-named. Unless this is the case, the entire concept will be completely undermined because patient concern will become obvious. Moreover, on the points raised with regard to epileptic sufferers, where it has been presented that a particular brand has been found to be useful and has been consistent in terms of reaction and response, it should be used. However, it should not be allowed that the company should influence such a drug's use or otherwise. The company obviously has its own reasons for making the case and it must be possible to be able to set out, purely on the basis of the ingredients, to ensure the same purpose can be served by the use of the generic products.

Acting Chairman (Deputy Ann Phelan): One minute remains to the Deputy.

Deputy Bernard J. Durkan: It is amazing, when one starts off on one of these subjects that one can find lots of information one has left out and lots of other information that should be dealt with. I acknowledge the Minister is well aware of these issues, as we have discussed matters of this nature in the past but I will state simply that this legislation is highly beneficial from a cost perspective. Moreover, it could be equally beneficial to patients because it may help everyone to focus more clearly on the degree of patients' illnesses or complaints and on the need for everyone else to keep down the costs. While I will not go over the points made by other speakers, suffice it to say I cannot understand how the number of personnel in the health services almost doubled, or certainly increased by one third, in the short space of time between the abolition of the health boards and the introduction of the HSE. This raises many questions.

Minister of State at the Department of Health (Deputy Alex White): I thank Members for their important contribution to the debate on this Bill. I have taken careful note of all the insightful observations made in the course of the Second Stage debate. Some Deputies have indicated they intend to table amendments on Committee Stage. I assure them that I will carefully consider all such proposals and will respond to them in detail on Committee Stage.

However, I wish to refer briefly to some of the issues raised by Deputies during the Second Stage debate. A number of Members referred to the complexity of the legislation. While I accept this is complex legislation, I assure Members that this level of complexity is necessary to ensure the Bill provides a robust legislative basis to introduce generic substitution and reference pricing in Ireland. Sometimes legislation has an extraordinary level of complexity and difficulty, with a lack of accessibility, but it is important that the legislation can withstand scrutiny or challenge. It must provide for as many eventualities as occur at this point, which necessitates complexity.

Deputy Kelleher asked if regulations will be made setting out the mechanism by which reference prices will be set. I advise that section 24(3) of the Bill sets out the process the HSE must pursue when setting a reference price for or reviewing a reference price for a group of interchangeable medicines. Therefore, there is no necessity to provide for regulations in the setting of reference prices. With regard to what basket of countries will be used as a reference by the HSE when setting reference prices, the Bill provides that the HSE shall have regard to the equivalent prices in all other member states in which a relevant product is marketed.

I note that some Deputies are concerned that overly emphasising the principle that prices will be set to protect and not jeopardise continuity of supply could result in prices not being sufficiently reduced. As I mentioned earlier, section 24(3) of the Bill sets out the process the

HSE must pursue when setting a reference price or reviewing a reference price for a group of interchangeable medicines. Whereas the ability of the supplier to meet patient demand is a key criterion the HSE must have regard to when setting reference prices, particularly in a small market like Ireland, there are other criteria which the HSE must also take into consideration. These include the value for money afforded by the relevant product, the equivalent prices in all other member states where the product is marketed, the prices of therapeutically similar listed items and the resources available to the HSE. It is important to balance achieving best value for money for taxpayers with assuring continuity of supply for critical medical products. I am determined that this be done in the most cost effective and efficient manner as possible. Consequently, a core objective of this Bill is to achieve value for money while maintaining and improving levels of service.

A number of Deputies referred to the necessity to introduce measures to reduce the growth in volume of drugs prescribed under the community drug schemes. It is clear that the current rate of growth in the volume of items dispensed under the community drug schemes is unsustainable and needs to be addressed. In this context, it is essential that we control both the price and volume of medicines dispensed under the community drug schemes. There is substantial international evidence demonstrating the scope for improving the quality and safety of prescribing and dispensing practices and behaviours. In this regard, the HSE has established a clinician-led medicines management programme, the aim of which is to ensure that all people have access to the essential medicines they need, that the medicines are safe and effective and that they are prescribed and used rationally. An important task of the programme will be the focus on cost-effective prescribing and the reduction in drug expenditure through more rational prescribing. Proposed initiatives in this regard will include the identification of preferred medicines or medicines of first choice in high cost areas such as proton pump inhibitors and statins, as these two groups account for approximately 20% of all expenditure under the general medical services, GMS, scheme. Generic prescribing will also be promoted as it is generally accepted as the most cost-effective prescribing.

Another measure being considered is amending the misuse of drugs regulations relating to benzodiazepines and z drugs to ensure that these substances are used in an appropriate manner. Benzodiazepines, as a group of medicines, are commonly used to treat anxiety, sleep disturbances and insomnia and the so-called z drugs are used to treat insomnia. There is increasing evidence of dependence and inappropriate use of these medicines in Ireland. This problem is not unique to Ireland as statistics indicate overuse of these medicines is an international issue, with Europe having the highest average consumption of benzodiazepines internationally.

I will now turn to the crucial issue of safety of generic medicines. First, it is important that people are aware that generic medicines marketed in Ireland must be licensed and meet the requirements set down by the Irish Medicines Board in the same manner as originator medicines. Under the Bill, the Irish Medicines Board has responsibility for establishing and maintaining a list of interchangeable medicines, which will include both originator and generic medicines. In deciding whether to add a group of medicinal products to the list, the Irish Medicines Board must be satisfied that each medicinal product which falls within the group has the same qualitative and quantitative composition in each of its active substances as each of the other medicinal products which fall within the group; is in the same pharmaceutical form as, or in a pharmaceutical form that is appropriate for substitution for, each of the other products in the group; and has the same route of administration as each of the other medicinal products which fall within the group. In addition, the Bill provides that the board is not permitted to add a group of me-

dicinal products to the list of interchangeable medicinal products where, for example, any of the medicinal products cannot be safely substituted for any one or more of the other medicinal products in the group.

To enhance further the patient safety aspect of generic substitution, section 13 of the Bill allows a prescriber to indicate on a prescription that a branded interchangeable medicinal product should, for clinical reasons, not be substituted. A number of Deputies referred to the concerns raised by the organisation Brainwave with regard to generic substitution of epilepsy drugs. I am satisfied that the provisions in the Bill address concerns people may have with the safety of generic substitution, including those concerns raised by Brainwave. We are proposing to provide for a power of substitution, subject to a very strict regime, and there is no provision within the Bill constituting a direct decision to substitute a product. There is a provision for a power to be exercised by the Irish Medicines Board to introduce a substitution, which is an important distinction to be recognised by colleagues, particularly in the context of legitimate concerns about particular areas, such as people living with epilepsy. We will have the opportunity to tease out more detail on Committee Stage if colleagues bring amendments. The Bill does not in itself bring about any substitution but rather provides a legal framework within which the Irish Medicines Board may introduce substitution. Any decision would be subject to a very rigorous regime. I repeat the key message that must be communicated by all associated with the implementation of generic substitution: generic medicines must meet the same quality and safety standards as originator medicines and have the same benefits and risks as originator medicines.

I wish to reiterate my commitment and the commitment of this Government to maintain and improve access to medicines for Irish patients. As I have stated, this needs to be done in the most cost-effective and efficient manner. The core objective of this Bill is to achieve value for money while maintaining and improving levels of service. By cost-effective I mean paying the most appropriate price for a particular product and there is no longer any justification, if there ever was, for paying a premium for a particular brand of medicine when an equivalent medicine, as assessed by the Irish Medicines Board, can be supplied at a much more competitive price.

It is important to emphasise that patients will continue to be able to obtain their necessary medications from their community pharmacist and that patients and taxpayers will benefit from paying less for these medications. Moreover, this Bill also provides that if in the opinion of a prescriber there is a clinical reason why a medicine should not be substituted, the patient shall receive the prescribed medicine at no extra cost.

The second core element of this Bill is the placing of the current HSE reimbursement list on a statutory footing. This is a timely provision and shall support the introduction of a system of reference pricing and generic substitution. The general criteria set out in the Bill and the regulations to come from it will assist the HSE in making timely decisions regarding reimbursement, provide clarity for the pharmaceutical industry on the application process and ensure the HSE achieves best value in the provision of medicines under the GMS and community drug schemes. I thank the House and look forward to the Bill being further considered on Committee Stage.

Question put and agreed to.

17 December 2012

Health (Pricing and Supply of Medical Goods) Bill 2012 [Seanad]: Referral to Select Committee

Acting Chairman (Deputy Ann Phelan): I understand it is proposed to refer the Bill to the Select Sub-Committee on Health. I call on the Minister of State, Deputy Alex White, to move the motion.

Minister of State at the Department of Health (Deputy Alex White): I move:

That the Bill be referred to the Select Sub-Committee on Health pursuant to Standing Orders 82A(3)(a) and (6)(a).

Question put and agreed to.

The Dáil adjourned at 1.30 p.m. until 2 p.m. on Tuesday, 18 December 2012.