



Houses of the
Oireachtas
Tithe an Oireachtais

An Coiste um Chuntais Phoiblí

**Tuarascáil maidir leis an Athbhreithniú ar
Incháilitheacht le haghaidh Cártaí Liachta
Deireadh Fómhair 2014**

Public Accounts Committee

**Report on the Review of Medical Card Eligibility
October 2014**



Foreword by the Chairman of the Public Accounts Committee, John McGuinness, T.D.

I welcome the report of the Committee on its examination of the medical card review process.

The medical card scheme is extremely important in making medical care assessable to those who cannot afford it. It is clear from the PAC examination that the vast majority of the card holding population are, following review, eligible to retain their cards. The focus of our report therefore was on examining ways in which the HSE can be more efficient and effective in applying control measures so that only those who have an entitlement hold a medical card.

The key point to emerge from this Report is the need for more work to be done on risk profiling so that compliant card holders are not subject to extensive review which is a waste of money given the known level of eligibility in the system. That system of risk profiling is now possible given that information can be shared with Revenue and with the Department of Social Protection and because the HSE now have a centralised data base containing almost two million card holders in the State. The other key issue to be addressed relates to the need for better systems of communication between the HSE and card holders so that the reviews do not end up frightening people into thinking that a review equates with losing their entitlement to a card.

The recommendations of the Committee should enhance the control systems in place in the HSE and also streamline the review process.

I commend the Report to Dáil Éireann.

**John McGuinness, T.D.,
Chairman,
Public Accounts Committee,
2nd October 2014**

Public Accounts Committee

Report on Medical Card Eligibility.

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Introduction

The medical card scheme is a cornerstone of our public health care policy enabling card holders to avail of health care that they would otherwise not be able to afford. The number of cards in circulation at end 2013 was 1,987,933 which equates to coverage of 43% of the population. The scheme, which covers GP and pharmaceutical charges, cost the HSE €1.7 billion per annum. In 2011 the HSE centralised the administration of the scheme and in 2012 commences a review of all card holders. By the end of 2013, the HSE had reviewed almost 1 million card holders and the proposal is that the entire medical card population will have been subject to review by the end of 2014. In 2014 and arising from a huge negative reaction by the public, the Government stalled the review of those medical cards that were allocated on a discretionary basis.

Accountability issues

The Committee examined the report of the C&AG on eligibility for medical cards [Chapter 22 of the Report on the Accounts of the Public Services 2012) at two meetings held on 14th November 2013 ¹ and on 12th June 2014 ² when the review of discretionary medical cards had been put on hold by the Government. The Accountability issues that arise and which are dealt with hereunder relate to:

- The compliance control systems in place
- The efficacy of the review process
- The need to develop a risk profile system
- The use of discretion in awarding a medical card
- Improving communications between the HSE and card holders

¹ [PAC Meeting 14th November 2013](#)

² [PAC Meeting 12th June 2014](#)

Chapter One

Compliance controls

Introduction

As outlined in the introduction, the provision of medical cards covers 43% of the population and takes up over 12% of the HSE's budget. In that regard and taking account of the findings of the C&AG that there appears to be a material level of ineligibility of card holding in the medical card scheme, it is important that the HSE has processes in place to maximise the extent to which only those who have an entitlement are given a card. This chapter examines the effectiveness of these control measures.

Determination of eligibility

The scheme conferring eligibility to a medical card was outlined to the Committee by the Accounting Officer of the Department of Health who stated as follows:

"As Deputies may be aware, the legislation governing the medical card scheme, section 45 of the Health Act 1970, as amended, allows for persons who are unable, without undue hardship, to arrange a general practitioner's service for themselves or their family to qualify for a medical card. Under this legislation, the determination of eligibility for a medical card is the responsibility of the Health Service Executive. Section 45 requires the HSE to have regard to the overall financial circumstances of a person and his or her spouse or partner in view of their reasonable expenditure. The HSE gives effect to the legislation and the Government's policy through its medical card national assessment guidelines. Where a person's income is in excess of the thresholds set out in the national assessment guidelines, the HSE uses its discretion to grant a medical card to a person who is unable, without undue hardship, to arrange a GP service. In doing so, it is obliged to have regard to the financial position and expenditure of the individual and his or her dependants.

To dispel any misconception that there still might be, I want to clarify that, in line with the legislation I have just outlined, there has never been an automatic entitlement to a medical card on the basis of having a specific illness or condition such as cancer. While there may be criticism of that approach, the correct interpretation is very clear from a reading of the legislation which has been in place for a considerable period of time.

There is an additional arrangement available to persons aged 70 years and over to establish their eligibility for a medical card. Persons over 70 years of age can also qualify for a medical card on the basis of a gross income test. Under the legislation, individuals aged over 70 years with a gross income not exceeding €600 per week qualify

for a medical card. Couples over 70 years of age with an income not exceeding €1,200 per week also qualify for a medical card.”

The Committee was informed that the number of people who were deemed eligible for a card increased by over 700,000 since the end of 2005: Between 2005 and 2012 the percentage of the population with a medical card rose from 27.7% to 40.4%. In that time period also the level of unemployment rose from 4.3% to 14.4% which shows that the direct correlation between the increase in the card holding population and the increase in the level of unemployment in the economy. In addition, as the criteria for qualification for those over 70 is based on gross income and not a means test and, as that segment of the population is increasing, there are demographic pressures leading to an increase in the number of card holders. As against that, there is churning in the system with the death of card holders, some card holders will have emigrated and with the increase in the number of jobs in the economy over the past two years, a percentage of card holders will have resumed employment and should no longer qualify to hold a card.

Reviews of eligibility

The administration of the medical card scheme processing was centralised in 2011 and the HSE now has a data base of all card holders and all decisions regarding the award of cards, especially discretionary cards, are now made centrally. In terms of control, the HSE has a rolling scheme of reviews that will see the eligibility of all card holders reviewed by the end of this year. The review of each card can be a self-assessment where the card holder has to confirm that his/her circumstances has not changed or it can be a full review, comparable to an initial application. In addition the HSE conducts focussed reviews that are determined by risk assessment. For instance, if a card has not been used over a twelve month period or if information that comes from the Department of Social Protection or the Revenue Commissioners gives an indication that the persons income may have changed.

Outcome of the 2012 Reviews

The HSE conducted two reviews in 2012, one being a general review of 366,000 card holders and the second was a focussed review of 40,000 card holders who had not used their cards in the previous twelve months. In the case of the general review, 70% of it was done by way of self-assessment and the remaining 30% was a full assessment. The following was the result:

The general review of 366,000 cases

10.7% did not respond and their cards lapsed [approximately 39,000}

1.9% of card holders were dead [7,000]

82.2% of card holders [301,000] had their cards renewed

1.5% of card holders [5,000] had eligibility reduced from a full medical card to a GP card

3.5% of card holders [12,800] were deemed not to be eligible and had their cards removed

The focussed review

The information given to the Committee shows that of the 40,000 card holders that had not used the card in a twelve month period, almost 40% of those had their eligibility removed.

The findings of the C&AG.

The Report of the C&AG reported, based on his review of the files, that in 8% of the sample reviewed there were shortcomings in the application of controls as there was no or inadequate documentation of outgoings and in 4% of cases the evidence suggested that the applicant had not met the eligibility criteria.

The outcome of the C&AGs audit is consistent with the outcome of the reviews by the HSE in 2012 in showing the need to address the level of ineligibility and also in developing a better risk profiling system so that the vast majority of card holders are left alone, in the same way as is done by the Revenue Commissioners for example who focus on levels of non-compliance.

Overall conclusion

The Committee, having analysed the outcome of the review conducted in 2012, concur with the views of the C&AG that there is a material level of excess expenditure which needs to be addressed. It is also the case that for the vast majority of card holders, who had their eligibility confirmed, that a focussed assessment based on risk should ensure that they need not be subject to such rigorous assessment and that this may be an ineffective use of HSE resources. It is also clear that greater attention should be placed on ensuring that the initial assessment of applicants is more extensive and that the HSE has all details on file to support the decision on the award of the medical card. The Committee will recommend that a greater focus is placed on initial controls with the review process being driven primarily by risk factors.

Chapter Two

The Review process

Introduction

One of the issues to emerge at the hearings with the HSE was the fact that the reviews conducted by the HSE had generated a huge level of anxiety amongst the general public. That reaction and the fact that many vulnerable people associated the review with losing their entitlement is an issue that needs to be addressed in future reviews. In addition the HSE needs to examine the extent of the burden that is placed on many card holders, some of whom are old, sick and may not have the ability to understand forms or to gather information to effectively re-apply for their medical card, which they had become so dependent on. The administrative burden on the staff working on the medical card scheme should also be reviewed as it is a paper based process involving millions of pieces of correspondence and the Committee emphasised on numerous occasions the difficulty caused where some of the correspondence is lost. The HSE was not in a position to outline how much these reviews cost which also needs to be considered. This chapter examines the efficacy of the systems and examines how reviews can be conducted more efficiently and effectively.

The Efficacy of the Review Process

In the 2012 review, of the 366,000 card holders reviewed, over 300,000 had their eligibility confirmed. The issue the Committee wanted to pursue was whether a review system could be put in place whereby that 80% plus cohort could have their medical cards extended without a formal review. In addition, the 1.9% of deceased card holders are not a cost on the system as the capitation grant is recouped from the GP from the date the card holder died. The two key groups therefore are those that make a return which shows they no longer have a full or partial entitlement (approx. 5%) and the larger cohort whose cards lapse as they do not engage in the process (the 10.7% group). It is the Committee's view that better risk profiling by the HSE of the card holding population would enable it to concentrate its review activity on those most likely to have questions marks in respect of eligibility. In that regard the HSE can now use information from the Department of Social Protection and from Revenue in order as part of its profiling processes.

Better Risk Profiling

The Committee is aware, having regard to evidence taken for instance from the Revenue Commissioners, that focussed reviews based on risk achieve better outcomes and customers who are compliant are left alone. That model now needs to be replicated

at the HSE. The HSE does not prosecute those who do not surrender their cards even though they no longer have an entitlement. Given that cards have a three year life span, the effort in pursuing those who fail to surrender cards is a pragmatic approach given the likely costs associated seeking to recoup monies from card holders. The culture that has developed in the card holding population is one where cards are not surrendered. That may be because there is no risk of being prosecuted and also the card, in addition to covering medical costs, gives an entitlement to claim a range of secondary benefits such as free school transport. The onus therefore falls on the HSE to target cases where there is a risk that entitlement has lapsed.

One of the obvious signals that eligibility may have lapsed arises when a card is not being used. As borne out by the focussed review of 40,000 cards holders who had not used their cards in over a year in 2012, the HSE was able to remove 40% of the cohort. There must be a strong possibility that some of that 40% had emigrated. It is also likely that, in the case of the 10.7% that did not engage in the general review and who allowed their cards to lapse that many had emigrated.

The likely second reason why card holders did not engage in the review is that their circumstances had changed and the focus of the HSE should be on detecting those at an early date. Through data matching with returns made available by Revenue and the Department of Social Protection, the HSE should be able to focus on those whose income indicated that they fall into a high risk category and should be thus given a high priority in terms of a review.

Information sharing

The sharing of information by public bodies with the HSE not alone enables data matching which can be used to build risk profiles of the medical card holding population but it can also facilitate decision making in respect of the application of individuals for a medical card. It makes sound administrative sense that the outcome of a means test conducted by the Department of Social Protection which results in a non-contributory pension being awarded should be sufficient to the HSE to either award a card or to ensure that the card is extended without recourse to the individual card holder. The Committee will recommend that the HSE make full use of the outcome of means assessments conducted by the Department of Social Protection when awarding a card or when conducting a review.

Random audits

One of the challenges facing the HSE is that they do not have an accurate estimate of the level of excess payments in the medical card scheme. A random audit of a sample of card holders can give a snapshot of the levels of ineligibility and can give the HSE an insight into where it should focus its control measures. A cyclical programme of random

audits will over time show trends that will also allow the HSE to evaluate the effectiveness of its control procedures. This type of audit will also allow the HSE to develop an accurate estimate of the extent of excess payment. The Committee endorses the recommendation of the C&AG on the use of random audits and will recommend that the HSE publish the outcome of such audits.

Conclusion

There is now a need to refocus the review process away from general reviews and towards focussed reviews based on the intelligence/data that is gathered through assessment of non-usage and also from the income profiles of card holders which can now be made available to the HSE from both Revenue and the Department of Social Protection. The HSE can also evaluate the level of ineligibility and also the effectiveness of its own control processes through a cyclical system of random audits.

Chapter Three

Discretionary Medical Cards.

Introduction

The Committee was informed that where an individual does not qualify for a medical card arising from an assessment of means, they may be granted a discretionary card if they cannot access medical care without undue hardship. Prior to the centralisation of the medical card administration process, discretion was exercised at local level which did lead to a situation where there was a lack of uniformity in the assessment process which resulted in an uneven spread of discretionary medical card holders across the country.. Committee members highlighted the fact that many holders of discretionary medical cards had life-long medical conditions and that the withdrawal of those cards was traumatic on the card holders and their families. Approximately 5% of the medical cards are awarded on a discretionary basis. The State ceased the review of discretionary medical cards in 2014 until it finalises a review of the medical card scheme which is examining the award of medical cards on criteria such as a medical condition or a disability.

Outcome of the Review of discretionary medical cards

The Committee was informed that as at 1st March 2011, discretionary medical cards had been allocated to **97,121**. At the end of October 2013, 38,283 of this group still had a discretionary medical card and a further 41,779 had migrated to a medical card based on means. In that time-period also, 2,361 card holders died.

The balance [**14,698**] no longer held a medical card. In this latter group were three cohorts, namely:-

1. **6,265** did not engage in the review process and their cards were suspended
2. **2,109** did engage but failed to produce the evidence of medical costs which would have allowed a fresh decision to be made on their entitlement and their cards were suspended
3. **6,324** engaged in the review, the outcome of which was that they no longer had an entitlement to a medical card

Legacy issues

The fact that many card holders who had serious medical conditions were now being told that they did not qualify for a medical card presents a major difficulty and public pressure ultimately led to a suspension of this element of the HSE review. It is a policy issue ultimately as to whether entitlement to a medical card can be based on a prescribed medical condition and the Committee welcomes the current review of the scheme which is focussed on this issue. The Committee, while accepting the HSE position that it had to implement the current legislation, is of the view that the legacy issue was itself created by the HSE when using discretion in awarding the cards. In that regard greater care should have been taken with this vulnerable group, many of whom suffered from medical conditions that were not going to change. In support of this position the Committee would point out that many who fell into this category would have an entitlement to benefit from the long term illness scheme and therefore the extent of the savings to be made by withdrawing the discretionary medical card would be diminished. In that regard the Committee will recommend that an assessment be undertaken which compares the cost of maintaining a person with a condition that qualifies automatically for the long term illness scheme as compared to someone with that condition who has a discretionary medical card.

Conclusion

Over 6,000 discretionary cards were withdrawn between 2011 and 2013, and given the public concern that arose from this, that review was stalled in 2014 while the policy of granting medical cards based on a medical condition was being examined. Some of the reasons for withdrawing cards related to a legacy issue arising from the lack of a uniform approach to the granting of a discretionary medical card by HSE districts prior to the centralisation of the system. The matter should have been handled in a more delicate fashion by the HSE given the fact that many of these cardholders were initially granted a card because of their long term medical condition.

CHAPTER Four

Customer Service

Introduction

One of the issues to emerge from the hearings on the medical card scheme relates to the customer service practices of the HSE. There are two aspects to this, namely the interaction of the public with staff working in the centralised PCRS or at the outsourced call centre which is based in Waterford and the second issue relates to the nature of written communication from the HSE. The Committee accepts that there are benefits to centralising a service, especially in terms of costs, however centralised systems take a time to bed-down and often the staff employed in the centralised system do not have the background or expertise of those who previously delivered the service. That is why it is hugely important that change management projects such as the centralisation of the medical card scheme is rolled out over time and that there are ongoing capacity reviews of the systems and structures so that the level of customer service does not deteriorate in the change-over period. The Committee has already reported on the poor management of the change process which led to a large backlog developing in 2011. The whole level of customer service and the need for better communications remained an issue when the matter was examined by the Committee in 2013 and 2014.

Customer Service Issues

Members raised concerns about the quality of customer services in particular as:

- (i) in many cases, clients have to deal with a different staff member regarding a discrete application or other issue each time they contact PCRS. There is no system in place where one staff member is the primary interface between the client and the PCRS. This lack of continuity is particularly problematic and frustrating in more complex cases.
- (ii) there are high levels of mislaidd documentation. Many medical card applicants, such as elderly people, are not readily able to copy documents before they submit them. The loss of such documents can lead to high levels of stress and anxiety among already ill people.

The HSE needs to examine both of these issues. The reviews involved huge movements of paper based application forms, much of which is unnecessary. Given better profiling, the majority of card holders should have their continued entitlement conferred

automatically unless the card holder brings a change of circumstances to the attention of the HSE.

On the issue of phone contact between clients and the PCRS in Finglas, there should be a review of case handling so that a dedicated unit are given the cases which require ongoing contact with the client and in this way there is greater continuity and the client will get a certain level of assurance in dealing with officialdom. The HSE should examine the feasibility of establishing a referral unit within the PCRS so that cases that are not straightforward are referred to trained staff who can deal effectively with customers.

Communications with card holders

One of the issues to emerge arising from the review process was the extent to which a fear emerged in the card holding population. That fear was generated by the perceived threat that the card would be taken away. The initial letters from the HSE were unduly complex and bureaucratic and needed to be amended. What has emerged from the process, as highlighted at the Committee meetings, is the need for a public education exercise to coincide with any review so as to assure customers as to what is happening so that for instance elderly patients are encouraged to respond. Instances were highlighted at the Committee where elderly people misplaced the letter or did not open it and this led to instances card lapsed unbeknownst to the individual or to their relatives as the issue only surfaced when the card was being used.

The second issue relates to the need to tailor the letter writing style to the targeted audience, many of whom are elderly and vulnerable due to illness. Messages need to be clear and straightforward but should be couched in reassuring terms which would encourage the card holders to engage with the HSE. Finally, greater care is needed in the way questions are asked so as to avoid as far as possible the likelihood that the recipient will misinterpret it as asking whether there is a change in their long term illness or their disability.

Conclusion

The HSE needs to review its operations at the PCRS centre so that it becomes more customer focussed. A dedicated unit within the PCRS that can handle the more complex cases would improve customer services and there is a need to cut down on the level of paper that is generated through the review process as the current level of transactions results in large numbers of forms being mislaid. Finally a public awareness campaign would help in bring clarity to the review process and ensure that the negative connotations that were associated with the recent reviews are not repeated.

CHAPTER Five

Findings and Recommendations

Findings.

1. The increase in the number of medical cards in circulation coincided with the economic downturn since 2008.
2. The HSE has since 2011 conducted a review of the medical card eligibility which has resulted in a significant cohort of card holders losing the entitlement. The majority of those who lost their cards did not engage in the review process which indicates that either their circumstances have changed or they no longer reside in the State.
3. Following on from the centralisation of medical card processing and arising from the access that is now available to data from the Revenue and the Department of Social Protection, the HSE is now in a position to review eligibility using risk as the main criterion.
4. The C&AG have found that weaknesses in controls at the initial application stage are likely to result in at least 4% of the cohort of card holders being incorrectly given a card.
5. Of the cohort of medical card holders who engaged fully in the general review process, approximately 4% had their eligibility withdrawn.
6. The HSE does not have an accurate assessment of the level of overpayment in the medical card system.
7. A legacy issue has arisen in respect of the award of discretionary medical cards due to a lack of uniform decision making by the HSE and district level which resulted in an uneven spread of discretionary medical cards across the State.
8. Evidence was given of cases where people with a life-long medical condition had lost their entitlement to a discretionary medical card. It is unclear the extent of the savings to be achieved by the withdrawal of these cards in view of the fact that many would qualify for under the long term illness scheme.
9. The HSE does not have a cost figure for the general reviews of medical card holders.
10. The process whereby 30% of the general reviews involve in effect a new application is placing undue pressure both on the applicant and the system.

Recommendations.

1. A comprehensive Risk Profiling system should be developed at the PCRS as a matter of top priority. Information on earnings from the Revenue and from the

- Department of Social Protection should enable the HSE to build up a profile the data base of card holders.
2. Those medical card holders who have a high risk profile should be priorities for review purposes.
 3. The HSE should examine ways of extending medical cards automatically for the 80% plus cohort of card holders, whose eligibility is in little doubt, having regard to their low risk profile.
 4. The HSE should review its control procedures so as to devote the majority of its available resources to the initial award process and to the focussed reviews.
 5. The HSE should conduct an exercise in the case of persons with a long term medical condition or disability which would compare the costs of granting those persons a medical card as against reimbursing their costs under the long term illness scheme.
 6. The HSE should conduct random audit of its medical card base which will give an indication of the extent to which excess payments are in the system and it will also over time allow the HSE to assess the effectiveness of its own control measures.
 7. Given the evident anxiety of the medical card holding population arising from the review process, the HSE should review its communication strategy and engage in a public awareness campaign to coincide with any future reviews.
 8. The HSE needs to review its customer care practices at the PCRS so that complex cases are dealt with by a specific team where the card holder can deal with one official who will become the case manager.

Orders of Reference of the Committee of Public Accounts

(1) There shall stand established, following the reassembly of the Dáil subsequent to a General Election, a Standing Committee, to be known as the Committee of Public Accounts, to examine and report to the Dáil upon—

(a) the accounts showing the appropriation of the sums granted by the Dáil to meet the public expenditure and such other accounts as they see fit (not being accounts of persons included in the Second Schedule of the Comptroller and Auditor General (Amendment) Act, 1993) which are audited by the Comptroller and Auditor General and presented to the Dáil, together with any reports by the Comptroller and Auditor General thereon:

Provided that in relation to accounts other than Appropriation Accounts, only accounts for a financial year beginning not earlier than 1 January, 1994, shall be examined by the Committee;

(b) the Comptroller and Auditor General's reports on his or her examinations of economy, efficiency, effectiveness evaluation systems, procedures and practices; and

(c) other reports carried out by the Comptroller and Auditor General under the Act.

(2) The Committee may suggest alterations and improvements in the form of the Estimates submitted to the Dáil.

(3) The Committee may proceed with its examination of an account or a report of the Comptroller and Auditor General at any time after that account or report is presented to Dáil Éireann.

(4) The Committee shall have the following powers:

(a) power to send for persons, papers and records as defined in Standing Order 83(2A) and Standing Order 85;

(b) power to take oral and written evidence as defined in Standing Order 83(1);

(c) power to appoint sub-Committees as defined in Standing Order 83(3);

(d) power to engage consultants as defined in Standing Order 83(8); and

(e) power to travel as defined in Standing Order 83(9).

(5) Every report which the Committee proposes to make shall, on adoption by the Committee, be laid before the Dáil forthwith whereupon the Committee shall be

empowered to print and publish such report together with such related documents as it thinks fit.

(6) The Committee shall present an annual progress report to Dáil Éireann on its activities and plans.

(7) The Committee shall refrain from—

(a) enquiring into in public session, or publishing, confidential information regarding the activities and plans of a Government Department or office, or of a body which is subject to audit, examination or inspection by the Comptroller and Auditor General, if so requested either by a member of the Government, or the body concerned; and

(b) enquiring into the merits of a policy or policies of the Government or a member of the Government or the merits of the objectives of such policies.

(8) The Committee may, without prejudice to the independence of the Comptroller and Auditor General in determining the work to be carried out by his or her Office or the manner in which it is carried out, in private communication, make such suggestions to the Comptroller and Auditor General regarding that work as it sees fit.

(9) The Committee shall consist of thirteen members, none of whom shall be a member of the Government or a Minister of State, and five of whom shall constitute a quorum. The Committee and any sub-Committee which it may appoint shall be constituted so as to be impartially representative of the Dáil.

APPENDIX 2

Membership of the Committee of Public Accounts – 31st Dáil

Áine Collins TD ¹	(Fine Gael)	
Paul J Connaughton TD	(Fine Gael)	
Joe Costello TD ²	(Labour)	
John Deasy TD	(Fine Gael)	
Robert Dowds TD ³	(Labour)	
Seán Fleming ⁴	(Fianna Fáil)	
Simon Harris	(Fine Gael)	
Mary Lou McDonald TD	(Sinn Féin)	
John McGuinness TD	(Fianna Fáil)	Chairman
Eoghan Murphy TD	(Fine Gael)	
Derek Nolan TD	(Labour)	
Kieran O'Donnell TD	(Fine Gael)	Vice Chairman
Shane Ross TD	(Independent)	

NOTES

1. Deputy Áine Collins appointed to the Committee by order of Dáil Éireann on 18 July 2013 in place of Deputy Pascal Donohoe who was discharged on his appointment as Minister of State 12 July 2013.
2. Deputy Joe Costello appointed to the Committee by order of Dáil Éireann on 17 July 2014 in place of Deputy Gerald Nash who was discharged on his appointment as Minister of State 17 July 2014 having replaced Deputy Anne Ferris on 8 May 2012.
3. Deputy Robert Dowds appointed to the Committee by order of Dáil Éireann on 17 January 2013 in place of Deputy Colm Keaveney who was appointed on 28 November 2012 in place of Deputy Michael McCarthy.
4. Deputy Seán Fleming appointed to the Committee by order of Dáil Éireann on 21 June 2011 in place of Deputy Michael McGrath.