The Irish Health Service
Vision, Values, Reality

The Adelaide Hospital Society
and
The Jesuit Centre for Faith and Justice

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June 2007

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1. Introduction

There is deep disquiet in Ireland about the state of our health service. From time to time, particularly in relation to overcrowding and long delays in hospital accident and emergency departments, this disquiet manifests itself as anger and even outrage. Irish people are unhappy that in such affluent times our health system is so dysfunctional. We are often promised a 'world-class health service' but experience shows that the Irish health care system falls far short of that.

The problems are numerous and occur in all aspects of the service – from the failure to implement effective polices for health promotion and illness prevention, to the uncoordinated and patchy provision of primary care services, to the inequities and gaps in hospital services. Nonetheless, it would be wrong to suggest that all is gloom and doom: there have been good initiatives at almost all levels of the health service, and indeed patients often speak highly of the standard of care and dedication of staff when they do succeed in accessing suitable treatment. However, it is hard to escape the impression that the system is in a state of 'permanent crisis'[1] and that this arises from a 'system-failure.[2] In addition, the situation is characterised by the absence of clear agreement about what exactly the problem is, and by uncertainty and ambiguity as to how improvements might be made.

The Health Strategy, *Quality and Fairness: A Health System for You*, issued by the Government in November 2001, was an attempt to address this dire situation over a ten-year timeframe. Already we are more than half-way through this period and there is little confidence that a solution is being found. In public discourse, the view is often expressed that, even allowing for the compensation required for years of under-funding in the 1980s and 1990s, spending on health is currently more than sufficient and the disappointing results must be due to something else – for example, bad management. In a society that is market-oriented, there is at least a cultural openness to proceeding to address inadequacies in the system by means of public–private partnership of different kinds.[3] However, there is also deep unease about this approach, a sense that weighting the public–private mix in Irish health care more firmly in the direction of private provision is deepening the institutionalisation of what is in practice an unjust two-tier system.

The temptation in responding to crisis situations is to go for short-term solutions that may only deepen the problem over the longer term. A different approach is to step back from the urgency of the immediate difficulties and ask ourselves some more basic questions: what sort of vision do we have for our Irish health service, and what sort of values and principles do we want to inform it? Perhaps with a map of this kind we are in a better position to return to our present situation, to audit the direction of policy, to suggest alternatives where necessary.[4]

The Irish Health Service – Vision, Values, Reality has been developed jointly by two Christian organisations: the Adelaide Hospital Society and the Jesuit Centre for Faith and Justice. It therefore reflects both a Catholic and a Protestant perspective on the values which should inform the development of the Irish health service.

The Christian background in which this paper's analysis is rooted is shared by many, but by no means all, people living in Ireland today. If, increasingly, political and cultural philosophers in Western liberal democracies[5] are more open to hearing the religious voice in public debate, they are so in a context where reason and persuasion frame debate and there are no special privileges accorded to revelation and religious authority. We are happy to enter the debate on these terms, confident that the Christian position is consistent with reason, that the faith perspective will provide a helpful horizon for those who share it or may be interested in it, and hopeful that as citizens we may contribute in a constructive way to a debate that concerns us all.

2. The Value of Values

International literature on health care increasingly emphasises the importance of values in ensuring effective health care systems. Thus the *Health for All Policy Framework for the WHO European Region* states: '*Health for All* is and has always been about values, and the *Health for All* policy framework links a set of basic values to the development of health policy.'[6]

Marshall Marinker has written:

> [Values] 'colour our aspirations and shape our judgements ... define our relationships, explain the organisations that we create and how we behave in them ... determine the goals we set ourselves ... explain how we judge ourselves, and the behaviour of others.'[7]

Values provide direction for a key task in designing and sustaining our health care system – namely, making choices: choices as to who gets care, which type of care is provided, who pays for care and how we pay for care. Most importantly, values inform the quality of care provided because health care is fundamentally about human beings caring for other human beings and the quality of that interaction is shaped by the values we bring to it.

The operant values in the formal health care system are largely determined by the political context. Citizens are ultimately accountable for that context in so far as they provide the mandate for their elected representatives to make choices about which values to uphold and prioritise and which values may be compromised when other factors such as taxation levels are involved.

However, as Marc Danzon, WHO Regional Director for Europe, has pointed out 'a sort of chasm' can exist between the espoused official values and the policy decisions and actions taken in health systems. He notes:

> On one side there are values, seen as inspirational, taken for granted, self-explanatory general statements. On the other side there is the reality of policy making in public health. The headline preambles and the detailed texts do not always link. It is easy to use values as a mantra rather than as an agenda.[8]

It can be argued that the Irish health system provides a vivid illustration of using values 'as a mantra rather than as an agenda'. The Health Strategy, *Quality and Fairness*, adopted the following principles:

- Equity and fairness
- People-centredness
- Quality of care
- Accountability

These principles were put forward to support a 'new vision' for our health services for every citizen:

A health system that supports and empowers you, your family and community to achieve your full health potential.

A health system that is there when you need it, that is fair, and that you can trust.

A health system that encourages you to have your say, listens to you, and ensures that your views are taken into account.

Yet the inadequacies of the existing system, as well as some of the current directions of reform, point to the significant gap that exists between the vision and principles espoused and the reality of Irish health care.

3. Vision and Values

3.1 Vision

The dignity of each and every human being, as expressed in the Universal Declaration of Human Rights, is grounded in Christianity by the belief that each person is created by God in the image and likeness of God (Gen. 1:27), and that we ourselves are judged by how we treat others in this life (Mt. 25: 31ff). In the Christian anthropological understanding, the human person is a unity of body, mind and spirit. Jesus Christ understood his mission, including his healing ministry, in terms of empowering us to full human flourishing ('I have come that they may have life, and have it to the full' – Jn. 10:10). The ministry of Christ is the model and prototype for the Christian approach which sees health and health care as the right of all people, regardless of their economic, social or legal status.

Furthermore, the Christian view of the sacredness of the human person is that the destiny of each person is beyond the limitations of this life and that while sickness is an inevitable part of the human condition there is redemptive value in suffering, and in seeking to alleviate it where it cannot be removed. Health then is a human good, willed by God, and we are called as a society to provide for the health care of all.

The Christian vision of the person finds particular expression in the Christian ethic of *agapé*, an attitude of total goodwill to every other person that cannot be altered, and a desire for the good of every other person that cannot be destroyed by anything he or she is or does. In relation to health care, this ethic means that Christians would want to advocate for a health care system that is *universal* – for everyone, regardless of age, creed or income or ethnic background, and that is *holistic*, providing care for body, mind and spirit.

In proposing this kind of vision – similar in effect if not in language to the vision in the Health Strategy, *Quality and Fairness*[9] – we are already signalling that as an important human good, a right, health and health care are not simply commodities of more or less optional value to be left to the market to provide. In these days, there is a growing cultural predisposition to trust the market, and this is especially the case in the Ireland of the Celtic Tiger. The Christian tradition acknowledges the benefits of the free market.[10] However: 'Left to itself, the market has no mechanism which ensures equity, either in access to health care or in acting upon the determinants of health that ensure equity in health outcomes.'[11] In other words, we cannot assume that the ordinary way in which commodities are traded will necessarily satisfy the deep human need to which health refers.[12]

The vision we put forward therefore encompasses something additional to that set out in the Health Strategy, quoted in the Introduction. Our vision is:

> 'A health system which is centred upon the dignity of every human being, which treats body, mind and spirit in a holistic way, and which treats each person upon the basis of their need rather than their financial status.'

3.2 Values

What kind of values ought to inform this vision? We set out four key values for the Irish health care system:

● Care

'At the heart of health care is caring.'[13] Caring refers to that aspect of health treatment which goes beyond technical expertise, which touches on the person as a person, which sees in professional expertise the possibility also of vocation. It is the recognition that when people are sick they may be vulnerable, dependent, needy, and issues of intimacy and trust come to the fore.

From a Christian perspective, this value is rooted in the regard that Jesus had for the whole person.[14] Pope Benedict XVI expresses the Christian roots of this position in his Encyclical, *Deus Caritas Est*: 'Love – *caritas* – will always prove necessary, even in the most just society'; the suffering person – in fact, every person – needs 'loving personal concern.'[15] This need is located in the nature of the human person as created by God, and it surfaces in a particularly acute way when we suffer, as when we are ill.

● Excellence

This refers to a high standard of technical care at all levels, which is well managed, gives value for money, and is comprehensive.

Setting and meeting standards is not enough. The development of a culture of excellence throughout our health system is essential to ensure the provision of high-quality integrated health care at local, regional and national levels to everyone on an equitable basis. Guaranteeing such excellence is fundamental to regaining people's trust in our health system. Each citizen is entitled to know that the care they are receiving is safe, based on best-practice evidence, and meets approved standards.

This value, from the Christian perspective, is rooted most particularly in the unique dignity of each human person, and in the context of God's 'yes' to creation ('God saw that it was good'), and of our stewardship of this creation.

• Justice

This refers to equity in terms of health status: as the Health Strategy acknowledged, a lack of equity results in '... differences in health which are not only unnecessary and avoidable, but, in addition, are considered unfair and unjust.'[16] It refers also to equity in terms of access to and quality of care, requiring that these should be determined on the basis of health needs rather than income status.

It remains of course to establish what, in concrete terms, is to be considered unfair and unjust, how equity relates to equality, but already to agree on a value helps to give direction. Justice also includes accountability: obviously, for the spending of resources, including demonstrating value for money, but also in terms of a more transparent presentation of how different categories of people benefit from our system.

We have already noted the deep roots of this value in the teaching and practice of Jesus Christ, as well as its resonance in other faith communities.[17]

• Freedom

Freedom is at the heart of contemporary liberal democracies. In the health care context, it refers to issues such as the freedom of the patient to give or withhold consent to treatment and to expect a basic respect for certain rights (for example, the right to confidentiality and to information). It implies a people-centred approach to health and health care.

It includes also the notion of democratic participation in decision-making: the direct involvement of people, both individually and collectively, in shaping health policy and the delivery of health care.

Freedom is at the core of the Christian gospel. There, unlike the predominant model in contemporary liberal discourse, it refers just as much to the positive freedom to do good, to live the good life with others (the common good), as it does to freedom of the individual from undue restraint. We are proposing here a more socially-inclusive notion of freedom as found increasingly in revised versions of liberal political philosophy, which emphasise active citizenship and the common good.[18]

From Vision to Policy

It is a matter for debate as to how a vision and its accompanying values may best be realised. The identification of an agreed vision and values then does not of itself determine policy: this has to be decided upon in the light of concrete social and economic circumstances. And so all the problematic issues in our health care system – in terms of the level and source of funding, public–private mix, management and so on – are not automatically determined in the context of any particular agreed vision and set of values.[19] Nonetheless, a vision and an accompanying set of values may provide a useful principled slide-rule with which to measure specific policies: when we know what we want we are in a better position to decide on how to go about attaining it.

We do not expect that the vision and values outlined above will be considered particularly controversial: rather, we hope that they can be accepted by most people of goodwill. In this sense, they may form part of an 'overlapping consensus', even among people of otherwise different world-views.[20] They are, for example, not at all dissimilar to those outlined in *Quality and Fairness*, the 2001 Health Strategy. It remains to be seen whether in applying them to some aspects of the concrete situation of health care in contemporary Ireland we can throw some light on what we need to do to achieve what we want.

4. Reality

4.1 Inadequate Capacity

Excellence and quality of care in health services depend on the professional qualifications and the personal qualities, including commitment to excellence and care, of the personnel who deliver it. But the realisation of these values is also crucially dependent on the system within which professionals work providing them with the structures, resources, and supports needed to carry out their roles.

A major threat to excellence and quality of care in the Irish health service arises from the fact that in many respects the system lacks the physical infrastructure, levels of staffing and the overall capacity to adequately respond to the demands made upon it.

The recurring crisis in accident and emergency departments of acute hospitals is, of course, the most visible and well-publicised instance of a failure of excellence in Irish health care. The inordinate delays which many patients face, the fact that people, including those who are very elderly and frail, who have been deemed to need in-patient care may have to lie on trolleys for days while awaiting a hospital bed, the overcrowded conditions which create discomfort for patients, difficult working conditions for staff and an increased risk of infection, have all been regularly highlighted in recent years.

Some short-term measures have been deployed in response to the most serious effects of the current situation. There is acknowledgement that addressing the problems of A&E will involve changes in structure and management within these departments, with a greater number of consultant posts, and more 'out-of-hours' access to diagnostic testing, especially at weekends. However, it is increasingly recognised that shortfalls in provision in other sectors of the health service must be addressed also if the problems of A&E departments are to be solved.

Every analysis in recent years of the Irish health care system, both from official sources and from independent commentators, has drawn attention to these shortfalls and highlighted how every part the system – whether it be primary care, acute hospital services, mental health services, rehabilitation, continuing care, therapies and social supports – needs additional investment to meet current demand and to provide improved and expanded services.[21] To take some examples:

- **_Primary Care:_** As acknowledged in both the 2001 Health Strategy and the _Primary Care Strategy_, primary care services in most areas of the country are underdeveloped and the potential of this sector to meet the medical and social needs of local communities is largely unrealised. To a great extent, 'primary care' means GP services only; in many instances these are provided in settings that are not purpose-built and which provide doctors with limited access to diagnostic facilities. There is limited provision for out-of-hours services.

  Primary care does not currently have the capacity to provide the preventive and screening services or the continuing care for those with chronic conditions that could potentially be made available at this level of the health service. Liaison between primary and secondary services is not as well developed as it should be.

  Furthermore, primary care in Ireland is far from being able to make available the comprehensive range of services – practice nursing, public health nursing, pharmacy services, social work, physiotherapy, occupational therapy, counselling and psychological services – that should be provided in an integrated manner for all communities.

  The Health Strategy stated that primary care 'must become the central focus of the health system' and that the policy aim was to develop its capacity 'to meet the full range of health and personal social service needs appropriate to that setting'. It acknowledged that this would require significantly enhanced funding. However, in the years immediately following the publication of the Strategy, there was very limited commitment of funding for implementation of its proposals for primary care. In more recent times, there has been additional funding for this purpose and in the _National Development Plan_ published in early 2007 there is a specific commitment to provide funding for a national programme to develop primary care, with a target of having in place 300 primary care teams by 2008; 400 by 2009 and 500 by 2011.[22]

- **_Acute Hospital Care:_** The promise in the 2001 Health Strategy to provide 3,000 additional public hospital beds (2,800 acute in-patient beds and 200 day beds) over the lifetime of the Strategy was an acknowledgement by Government of serious under-provision of acute hospital places.

It appears that around 720 additional in-patient beds have been provided (just 26 per cent of the promised provision) along with 480 extra day beds [23] – though questions have been raised as to how real an increase in capacity this latter figure actually represents, since some of the growth in the numbers of 'day beds' appears to be due to the reclassification of recliners and chairs as 'day beds'.[24]

The World Health Organisation (WHO) in its figures for 2004 shows that Ireland has 57 beds per 10,000 people compared to a European average of 64.[25] However, there is not unanimous acceptance that Ireland needs additional acute public hospital beds. The argument is made that if account is taken of the beds that are available in the private sector and of the fact that the population over 65 – the group most likely to require hospital care – is proportionately lower in Ireland than in other European countries, the hospital bed ratio does not, in fact, compare as badly with the European norm as would first appear.

Yet the reality is that the numbers in the older age groups, in particular over 80, is increasing rapidly, and that the overall population of the country is projected to continue to grow. A study commissioned by the ESRI showed that, in the light of the impact of projected demographic change, between 1,821 and 3,280 extra acute beds would be required over the period 2007 to 2013.[26]

Inadequacies in acute hospital care relate not just to the number of beds available, but to insufficient consultant-provided, as opposed to consultant-led, services in public hospitals. Several major reviews have highlighted that Ireland needs significantly more consultant posts if acute hospitals' present degree of reliance on junior doctors who are not fully qualified in their specialty is to be addressed.

- ***Mental Health Services:*** The deficiencies in mental health services have been highlighted in *A Vision for Change*, *Report of the Expert Group on Mental Health Policy*, published in January 2006,[27] as well as several other reports from official sources, non-governmental organisations and professional bodies.[28]

Despite overall improvements in residential psychiatric facilities, there continue to be instances where the accommodation and services for long-stay patients in psychiatric hospitals are severely inadequate. Mental health care for acute and chronically ill patients too often fails to make available the interdisciplinary range of services (provided by specialist psychiatrists, clinical psychologists, community psychiatric nurses, occupational therapists, family therapists, social workers) that are generally agreed to be essential if the complex needs of people with mental illness are to be met.

There are serious inadequacies in services for children and adolescents. This is evidenced in insufficient numbers of specialists in child psychiatry, long waiting lists for outpatient appointments in the public system and a serious shortfall in the number of in-patient beds in specialised units, which sometimes leads to the inappropriate placement of young people in adult psychiatric units. Mental health services have been able to give only limited attention to preventive measures and to initiatives for the promotion of good mental health.

The gaps and inadequacies in mental health services result in patients being left without the supports necessary to recover from mental illness and consequently at risk of long-term disability, social isolation, and even homelessness, and in families having to take on extremely demanding caring roles.

Providing adequate mental health services will require far-reaching reforms, with improvements in core services, a wider range of therapeutic and support services and new structures for the delivery of services by multidisciplinary mental health teams within the community. The scale of the need for continued additional investment is indicated by the recommendation of the Expert Group that as many as 1,800 additional posts would be required to implement its proposals in full over ten years, requiring that, by the end of this period, non-capital investment would be €151 million greater than in 2005.[29]

The publication of the Report was followed by a Government commitment to implement the recommendations of the Review Group and additional funding has been allocated for this purpose (an extra €26.2 million in 2006 and a further €25 million in 2007).

- ***Extended Care and Support Services:***
  A major factor contributing to the crisis in acute hospital provision is inadequate provision of extended care and community nursing facilities for older people and people with chronic conditions requiring long-term care. Similarly, there are serious shortfalls in services, such as home helps for older people and those with chronic illness living in their own homes, and in supports, including respite services, for carers.

  Social services for families with children are seriously inadequate, with the focus on crisis intervention, so that preventive and support services are largely underdeveloped and often provided in an uncoordinated manner. Despite the fact that child protection is deemed to be a priority, there can be inordinate delays in accessing assessment and therapeutic services for victims of child abuse. Services for adults who are victims of violent and abusive relationships, and for their children who are indirect victims, are also only patchily available.[30]

Expenditure on Health

Underlying the gaps and inadequacies in provision, is a fundamental question: is funding adequate to provide an excellent service? Current expenditure on health has increased three-fold since 1997, and for 2007 is budgeted at €13.4 billion, with capital expenditure projected at €664 million. Current health expenditure will therefore represent 29.5 per cent of all Government spending in 2007, being surpassed in its share of expenditure only by the Department of Social and Family Affairs.

The substantial increase in expenditure *has* brought improvements and an expansion in services. For example, in the acute hospital sector, there has been a significant increase in activity, with more people treated in both in-patient and day patient facilities, and more expensive treatments provided, despite the failure to significantly expand bed numbers.

The argument is frequently made that in light of the dramatic increase in health expenditure over the past ten years, we need to accept that further improvements in services will have to come about mainly as a result of more efficient use of resources.

However, the increase in expenditure on health care needs to be seen in context. Firstly, the increase of recent years followed a decade and a half of very slow growth and a period in the late 1980s when expenditure fell sharply in real terms. This gave rise to an accumulated deficit in provision.

Secondly, the period of significant growth in expenditure on health is also one marked by notable increases in both the total population of the State and of the older age groups which are more susceptible to acute and long-term illnesses. In the inter-censual period 2002–2006, the overall population grew by 8 per cent. The population aged over 65 reached 467,926 in 2006, an increase of 31,925 (7.3 per cent) from 2002.[31] The population in the oldest age groups (80 and over) grew by 12 per cent between 2002 and 2006. It has been estimated by the Central Statistics Office that the population over 65 could be as high as 626,800 by 2016, which is 158,800 (or nearly 34 per cent) greater than the 2006 figure.[32]

Thirdly, Irish public spending on health needs to be seen in relation to the spending levels of other developed countries, and in particular those of other EU countries. Until relatively recently, Irish public spending on health per capita was well below the average for the 15 Member States that made up the EU until 2004. The increase in spending since 1999 has not, contrary to what is frequently asserted, resulted in Irish expenditure being greater than the EU average. A significant percentage (at a minimum 10 per cent and perhaps as much as 20 per cent) of 'health expenditure' in Ireland is in fact spending on social services and supports (such as social work, family support and home help services). Such spending is not part of the health budget in many other countries and therefore cannot be included for the purpose of comparing Irish health expenditure with that of other countries.

In May 2007, Maev-Ann Wren pointed out:

> OECD data show that Irish current spending on core health programmes peaked at 92% of the EU15 per capita average in 2002, fell to 88% in 2003 and was 90% in 2004, the latest year of available international data. There is no evidence that health spending has since advanced relative to the average.[33]

Irish society's aspirations for its health services, and its expectations about the level of expenditure needed to provide these services, have to go beyond looking at the recent trends in spending, however impressive these at first may seem. Our expectations have, instead, to take realistic account not only of the need to make up for past deficits and to provide for a growing, and ageing, population but to provide a level of service worthy of a country that is now one of the wealthiest in the world, with a per capita income that is above the EU average.

4.2 An Unjust System

Even in a health system that aims for universal provision, it is inevitable that access to and use of services will not always directly relate to need, given that some people will be better positioned, by virtue of, for example, educational or social status, to take advantage of the services that are available. In the case of Irish health care, however, inequity is an in-built feature, a structural characteristic, of the system. This is so despite the stated commitment of *Quality and Fairness*, the 2001 Health Strategy, and indeed of its predecessor, *Shaping a Healthier Future* (1994)[34] to making equity a core value underpinning the provision of health care.

Acute Hospital Care

In relation to acute hospital care, the lack of justice in the system arises from the fact that the speed of access to treatment and the quality of care received often depend not on the seriousness or urgency of the illness but on whether a person is a public or a private patient. The inequalities in access to, and quality of, care are all the more unacceptable, given that public patients are likely to be from the population groups which have a higher incidence of ill health (that is, lower income groups and/or older age groups).

Waiting lists

The establishment of the National Treatment Purchase Fund (NTPF), which enables people who have been waiting for treatment in public hospitals to be treated within the private system, has undoubtedly had an impact on the waiting times experienced by public patients. The stories of those who have availed of services under the NTPF may highlight the benefits to these patients of this system but they also reveal the inordinate delays that public patients may experience.[35] A survey carried out in early 2007 of people's experiences of waiting times for both outpatient and in-patient services showed – as did previous surveys – significant differences in the waiting times for public and private patients.[36]

The exact position regarding the numbers waiting for treatment and the length of wait in the public versus the private systems are, however, unclear. Statistics are not available on waiting lists for private patients. In relation to public patients, the method of recording those awaiting hospital treatment has been changed: the previous format was discontinued in 2003 and a new system in respect of the waiting lists of a limited number of hospitals was initiated in 2005. Since the end of 2006, the 'Patient Treatment Register', as the waiting list is now euphemistically called, covers all the hospitals included in the previous system. This shows that in December 2006 there were 15,096 adults and 2,300 children waiting for surgical procedures, and that over 30 per cent of both adults and children on the list had been waiting for more than a year. There were 4,425 adults and 402 children awaiting a medical admission to hospital; 35 per cent of the adults and 27 per cent of the children on this list had been waiting for over a year.[37]

These statistics do not adequately reflect the full scale of delay in accessing services since they include only people who have been waiting for more than three months and they do not reveal the extent to which patients have been waiting for a first appointment at an outpatient clinic in a public hospital. Since 2005, the NTPF has been arranging initial appointments with consultants on a private basis for those who have been on waiting lists for public outpatient appointments. The scale of the problem of lengthy outpatient waiting is highlighted in the acknowledgment by NTPF that some of those offered an appointment under this initiative had been waiting for up to five years.[38] Some GPs have been reported as being reluctant to even refer people to an outpatient clinic because the waiting list was so long that being on it might only add to the patient's distress.[39]

A further issue in relation to waiting lists is the need to ensure independence in the compilation of statistics. Assigning this role to an external agency such as the Central Statistics Office, rather than a body that is part of the system for providing access to services, would allow for greater transparency.

Quality of care

The lack of equity in hospital care is evident also in the quality of care received: private patients in hospitals have their medical care delivered by consultants; public patients receive 'consultant-led' treatment, with their care provided mainly by doctors who are still in training, whose working hours are unacceptably long and who may be inexperienced, and inadequately supervised. A national patient study in 2002 disclosed that almost a quarter of patients said they rarely or never saw their consultant.[40]

The basis of the two-tier system

Ireland's dual system of acute hospital care is the product of a series of policy choices over many decades and the consequences, unintended as well as anticipated, of these choices. Two elements that are key to the system are the designation of public

hospital beds, both in-patient and day beds, for the use of private patients and the 'common contract' for consultants.

Following the cutbacks in public expenditure on health care in the late 1980s, there was pressure on public hospitals to generate income by increasing the number of their beds assigned for use by private patients. The Health (Amendment) Act 1991 provided a statutory basis for the designation by public hospitals of a proportion of their beds for private use, subject to the approval of the Minister for Health. In theory, the public/private split in public hospitals was to be 80/20, reflecting the relative proportions at that time, but in reality the occupancy of public hospital beds by private patients has increasingly come to be much higher than this. A report by the Comptroller and Auditor General published in March 2007 noted that data for 2006 showed that private practice in public hospitals exceeded 20 per cent in all categories of clinical activity (elective, emergency in-patient and day procedures), in some instances by a significant degree. The report pointed out that overall private patients represented an average of 34 per cent of elective in-patient cases. [41]

In addition to the problem of insufficient availability of public hospital beds for public patients, there are important questions of equity, and of efficiency in the expenditure of public money, arising from use of public beds for private patients. The amount accruing to public hospitals from charges for private beds falls short of the actual cost of the care provided, and so 'private' care in public hospitals is in fact substantially subsidised.[42] Where beds in excess of the designated 20 per cent are used, further anomalies arise. Consultants' payments from insurance companies for treating private patients are unaffected by whether the patient is treated in a designated private bed or in a public bed in a public hospital. The insurance company actually benefits since it does not have to pay the cost of the hospital bed if this is not designated as a private bed, and so it has only to pay the consultant's fees. The hospital, accordingly loses and has to bear the full cost of providing the hospital bed accommodation.

The 'common contract' requires consultants to work just 33 hours a week in a public hospital for their public salary, and, depending on the type of contract, permits them to undertake fee-paying work in either the public hospital in which they are employed or in other hospitals, including those that are private. Since the contract also allows that care of private patients in the public hospital in which consultants are employed can count as part of the 33 hours contracted work, and furthermore explicitly permits them to delegate a non-

consultant hospital doctor to carry out the care of the public patients who have been referred to them, there are clearly significant financial incentives for consultants to prioritise work for private patients. In effect, hospital care in Ireland is structured in a way which ensures that the limited amount of consultant care available in the system will be rationed in favour of private patients. It is now widely agreed that the reform of consultants' contracts is a fundamental requirement if a consultant-provided service, an essential element in addressing the inequity in the care received by public patients, is to be put in place.[43]

National Treatment Purchase Fund (NTPF)

The NTPF, referred to earlier, was established in 2002, following on the commitment in the Health Strategy to 'introduce a new ear-marked treatment purchase fund to reduce waiting times'.[44] The Fund, which was put on a statutory footing in 2004, provides for the purchase of treatment for public patients who have been on waiting lists for more than three months. Treatment can be provided in a private hospital in Ireland, in a public hospital, or it may be purchased in Northern Ireland, Britain or elsewhere. Between 2002 and 2006, almost 55,000 people had in-patient procedures carried out under the NTPF; between 2005 (the start of its outpatients appointments initiative) and the end of 2006, almost 12,000 people were referred for outpatient appointments with a consultant.[45]

While the value of NTPF-provided services to the patients who have availed of them is clear, there are important questions to be raised about this mechanism for dealing with waiting lists for public patients. The system is arguably an expensive way of purchasing procedures privately that could have been delivered by increasing capacity in the public system, and it produces a strange circularity in Irish health care expenditure. Since most consultants in the private system also work in the public, the same consultants whose public patients have failed to obtain treatment in the public system may now be providing that treatment for a fee within the private system.

In 2002, the National Economic and Social Forum observed that it was a 'peculiarity' that the Government was 'turning to private suppliers to provide capacity for public patients, while dedicating some 20 per cent of existing public capacity to private patients.'[46]

Miriam Wiley of the Economic and Social Research Institute has commented that, in effect, the State was 'paying twice over for the provision of certain types of services' by subsidising both private patients' treatment in public hospitals and the displaced public patients' treatment in private hospitals.[47]

The fact that public hospitals can provide treatment under the scheme raises the question why they are not provided with sufficient funds under their ordinary budgets to carry out these treatments. The 2004 Annual Report of the Comptroller and Auditor General showed that in the cases he examined in detail, 44 per cent of procedures had been carried out in public hospitals and 36 per cent in the same public hospital from which the referral had come in the first place.[48] In 2005, a new policy of limiting public hospitals' role in providing NTPF treatment was introduced when its share was capped at a maximum of 10 per cent of the total. While this addresses the apparent anomaly that a mechanism that was intended to provide treatment primarily through the private system was in fact relying heavily on the public system, it also introduces a new anomaly whereby public hospitals that might have spare capacity are handicapped by the quota in competing with private hospitals for work under the scheme.

Need for radical action

Clearly, addressing the lack of justice in the acute hospital system will require more far-reaching measures than have yet been attempted. As far back as 1989, the Commission on Health Funding recommended the establishment of a common waiting list as a solution to the problem of the disparity in waiting times between public and private patients.[49] If implemented, this would have addressed the problem of the differential in waiting times for public and private patients, but it could not of itself address the differences in the type of care received. Nearly twenty years later, in the context of economic prosperity that was then unimaginable, it is surely time for Irish society to unambiguously commit itself to developing a system of hospital care that allows access to services on the basis of need.

More than thirty years ago, Irish society found it possible to eliminate the distinctions between public and private patients in the delivery of GP care; it is now time to start a process towards achieving the same goal in the delivery of hospital care. A study commissioned by the Adelaide Hospital Society[50] has shown that a system of social health insurance that would provide for equity of access is not a utopian ideal but rather is a realistic option for a society of Ireland's current standing as one of the world's richest nations. Many of the European countries which are recognised as having high-quality health care, providing comprehensive entitlement to services, have a system based on some form of social insurance.

Medical Card Eligibility

Issues of justice in accessing care also arise in relation to entitlement to medical cards, which provide free GP services and other primary care services, free prescription medicines and exemption from public hospital charges.

Apart from those over seventy, who since 2001 qualify for a medical card without a means test, individuals and families whose incomes are modest but still too high for entitlement to a medical card may face health-related costs that constitute a disproportionate share of their income.[51] Alternatively, they may be compelled to delay or forego treatment, with potential detrimental implications for their health, in both the short and long term. A 2004 Comhairle report noted:

> As well as causing financial problems ... the absence of a medical card causes anxiety and may result in mothers in particular neglecting their own health problems in order to ensure that their children get any necessary medical care.[52]

It is families with children and individuals who have chronic or recurring illness, particularly those who must take medication on a long-term basis, who are most seriously affected by exclusion from medical card eligibility.

The Health Strategy 2001 promised that 'significant improvements' would be made in the income guidelines for medical cards 'in order to increase the number of persons on low incomes who are eligible ... and to give priority to families with children and particularly children with a disability.' It promised further that 'the income threshold will be increased substantially and reviewed annually on an agreed basis. This would include taking account of changes in the cost of living and movement in relevant social welfare payments and allowances.'[53]

A failure to follow through with the approach proposed in the Health Strategy was reflected in a decline in the percentage of the population qualifying for medical cards. Whereas this had generally stood at between 35 and 38 per cent of the population, and in 1996 was 34.5 per cent, by September 2004, only 28.5 per cent had medical cards. When account is taken of the fact that this figure included people over seventy who had qualified on the grounds of age rather than income, the percentage of the population qualifying on the basis of income eligibility had fallen to 26.3 per cent.[54]

Two initiatives since 2004 have had some limited effect in mitigating but not fundamentally addressing the injustice of the curtailment of medical card entitlement. In November 2004, the Government announced that it would provide a new form of entitlement – the GP-only medical card. While this meets one element of the costs of medical care for

lower income people, it excludes significant other entitlements of a full medical card, notably coverage for the cost of prescriptions, public hospital charges, services such as occupational therapy or physiotherapy. It also results in exclusion from other benefits that are attached to having a full medical card: for families with school-going children, for example, a medical card means that they are not liable for school transport charges or second-level school examination fees.[55] The introduction of the GP-only card was not preceded by any published analysis of why this was considered an appropriate means of addressing the expense and anxiety faced by those on low incomes who were outside the limit of eligibility for a medical card.

The second initiative was the announcement, in October 2005, of an increase of 20 per cent in the net income guidelines for medical card eligibility, with provision that 'reasonable' housing costs, childcare expenses and travel to work costs would be taken into account. Even with these increases, some individuals and families solely dependent on social welfare payments for their income can find themselves excluded from entitlement to a full medical card.[56] This is in spite of the fact that in 2004, the Minister for Health and Children stated in the Dáil that it was her intention that those whose only income was a social welfare payment should be eligible for a (full) medical card.[57]

The failure to fulfil a commitment to increase the number of full medical cards must be seen in a context of increasing fees for GP visits and increased charges for public hospital services. Account must also be taken of the fact that the threshold for reimbursement under the Drug Refund Scheme has continually risen, so that a person must now spend €85 a month before they can claim reimbursement of prescription charges.

There is a strong case on the grounds of fairness for immediately extending eligibility for full medical cards so that the percentage of the population covered is again around 35 per cent. In the longer term, the objective has to be the provision of primary care free at the point of delivery to all the population, as is the norm in many developed countries.

4.3 Privatisation

While Ireland has long had a public–private mix in health care services, there has been a significant trend in policy in recent years towards greater reliance on private provision. This has important implications for realising the values of 'justice' in access to health care and in the quality of services received, and of 'care', understood as a holistic response to each person's needs.

The trend towards greater private provision is evident in a number of areas, including nursing home care, the new home care packages for older people, and in the development of facilities for multidisciplinary primary care provision. Some increased use of the private sector was signalled in the Health Strategy of 2001, but not on the scale to which it has occurred since then.

One factor in this trend has been the cap on public service recruitment introduced in December 2002. This has had the effect of pushing service provision in the direction of the private sector by, on the one hand, limiting the services available in the public sector, thus forcing individuals who need these services to resort to private provision and, on the other, pushing the public sector towards using private providers to supply service commitments.

Hospital Co-location

The most contentious element of the trend towards greater reliance on private care has been the proposal to co-locate private hospitals on the grounds of public hospitals. This, however, can be seen as the extension, of an earlier policy departure – the introduction of tax relief for the development of private hospitals in 2001, which was extended to for-profit private hospitals in 2002.

Despite their implications for the direction of Irish health care, neither the introduction of the tax relief nor the proposal to build private hospitals on the grounds of public hospitals was preceded by the publication of any policy discussion paper or by any public debate. Prior to the enactment of the legislation providing for the tax relief for private hospital developers there was no real debate on the matter in the Dáil; the proposed co-location of public and private hospitals was set out in a policy instruction by the Minister for Health and Children to the Health Service Executive, with no prior consultation with the hospitals concerned. Proposals to change policy on such a scale ought to have been the subject of rigorous analysis and vigorous public debate, which would have brought to the surface the immediate and the long-term implications of adopting them.

The rationale advanced for co-location has been that it represents a cheaper and quicker way of providing extra public beds: the proposed 1,000 new beds in these private hospitals, it has been argued, will 'free up' 1,000 beds in public hospitals currently allocated for private patients.

In reality, however, private hospital beds cannot be equated one-to-one with those in public hospitals, since private hospitals do not provide the full integrated package of care that is available in a public hospital but instead make available only selected

procedures, 'cherry picking' those that are less expensive to carry out, and avoiding those that are more complex or involve extended care for the chronically ill. In other words, an additional 1,000 private beds would provide only a limited portion of the services available through the equivalent number of beds in public hospitals.

Contrary to how they are portrayed, these proposed private hospitals would come at significant cost to the Exchequer, since they would be provided with the aid of tax breaks: it has been calculated that 40 to 44 per cent of the cost would fall on the public purse.[58] The fact that the public subsidisation of the building of private hospitals does not appear as an item of expenditure in the budget for health, but is instead tax foregone, does not mean it is any less a cost to the State. Yet the State would not even be a co-owner of these facilities. Meanwhile, those with sufficient money to make this kind of investment would have been enabled to reduce their tax liability and acquire a capital asset.

Furthermore, the building of private hospitals virtually within sight of public hospitals would send out a powerful message about Government backing and support for the existing two-tier system of hospital care: it would entrench that system and make it all the more difficult in the future to bring about change. It would also represent a significant departure from the long-established and proud tradition of Irish hospital care being provided on a not-for-profit basis, through the efforts of religious organisations and voluntary bodies.

From a long-term perspective, a particularly worrying element of this proposal is that it promotes the perception and the reality that health care is just another commodity to be bought and sold. It is no coincidence that over the past few years, public discussion about health and health care in Ireland is as likely (and often *more* likely) to feature the words 'market', 'competition' and 'investment', as it is to include the words 'patient', 'care' and 'service'.

The current policy direction is one that represents a significant threat to the fundamental values of care and justice, which require that health provision is seen first and foremost as essential service, which should be available on the basis of need, not income.

4.4 Population Health

All the values which this paper suggests should underlie health care – excellence, justice, freedom and care – require that the system should pay particular attention to preserving the health of individuals and promoting the overall health of the community. Ireland's status as one of the wealthiest countries in the world means that it has the resources, if it so chooses, to significantly improve the health of its people.

However, while Ireland may be one of the wealthiest countries in Europe, it is far from being one of the healthiest. There have been improvements in the life expectancy of both males and females over the past decade, and the rate of improvement has been better than the EU average. Nevertheless, only in the case of life expectancy at birth for males does Ireland perform better than the average for the EU25 countries. In relation to life expectancy at birth for females, and life expectancy at 65 for both males and females, Ireland is below the average for the EU25 and to an even greater extent below the EU15 average.[59] Of particular concern in terms of mortality, is the high incidence of suicide, where recorded rates have doubled over the past two decades, and of deaths from road traffic accidents, which together represent the principal causes of death among young people.

Unhealthy Divisions

Regrettably, Ireland does not have any system to make available, on a regular basis, data showing trends in the relationship between social class and mortality and morbidity. Nevertheless, a number of different studies over the past decade have served to build up a picture which shows marked disparities in health status and mortality rates according to income and occupational group.

Analysis of mortality data for the period 1989–1999 revealed that the overall mortality rate for the unskilled occupational group was 100 to 200 per cent higher than the rate for the higher professional group and that the disparity in mortality rates existed in relation to all the major causes of death – circulatory diseases, cancers, respiratory diseases, injuries from road traffic accidents and other causes, and poisonings.[60] The incidence of perinatal mortality and the risk of babies being of low birth weight has been shown to be significantly greater for the unskilled, semi-skilled and unemployed groups than for the higher professional group.[61] There is a markedly higher incidence of admission for treatment for psychiatric illness among unskilled and semiskilled socio-economic groups, and among those whose socio-economic status is 'unknown', than among higher occupational groups.[62]

A study of people's perceptions of their own health status showed that a much smaller percentage of those on lower incomes described their health as 'excellent' or 'very good' than did those from the higher income categories.[63] Other studies have highlighted that members of groups which face particularly severe economic and social disadvantage (for example, the Traveller Community, homeless people and the prisoner population), experience a high risk of physical and/or mental ill-health. Little wonder that nearly every Irish study that looks at social class health inequalities resorts to employing the phrase: 'Poor people are sick more often and die younger'.

Improving health and reducing health inequalities

To improve the overall health of the population and reduce health inequalities will require action to address health endangering behaviours, such as smoking, abuse of alcohol and drugs, poor diet and lack of exercise, as well as the provision of quality health services, including services for early detection and treatment.

It requires also responding to poverty and inequality in the areas of income, education, housing, the built environment and social amenities, as well as to the stresses associated with living on a low income, including those arising from not having employment or having only employment that is characterised by poor pay and conditions. It is now widely accepted that addressing inequality is necessary not just to improve the health of lower income groups but that of other social groups also, since inequality *in itself* poses a threat to the overall health status of a country's population. Among developed countries, it is those that are more equal which have better health profiles and life expectancy, and conversely it is those which are more unequal that are less healthy. If Irish society as a whole is to become more healthy it must become less unequal.

Clearly, the task of addressing social and economic inequalities, as well as some of the factors influencing health endangering behaviours, requires action that goes beyond that which can be undertaken by 'the health services': to a significant extent this is the responsibility of other government departments and agencies. Yet, this is not to deny or diminish the critical role which the health care system can and must play in improving health status and reducing health inequalities. In this respect, there are at least four key areas where action by the health sector is essential, and in all of these the present situation shows a need for radical improvement. These areas are:

- The adoption by the Minister for Health and Children and his or her Department of a 'population health approach' to the health policy. The Minister and Department must assume the lead role for drawing attention to the wider social factors that impact on health, for attaining overall Government commitment to address these and for securing cross-sectoral action in relation to them. This is not a role that can be left to the Health Service Executive – even though it clearly has a key part to play in promoting population health: it has already established a Population Health Directorate, and is undertaking various initiatives in collaboration with other bodies. However, as a statutory agency it does not command the authority to ensure that the cross-sectoral action required at central government level is put into effect.

The need for action at this level was explicitly recognised in the Health Strategy, which under its first National Goal of achieving 'Better Health for Everyone', set the specific objective of ensuring that 'the health of the population is at the centre of public policy'.

The Strategy stated that health should be given priority across all the sectors that impact on improving health status, and that it should be a core value at the strategic planning stage for all government departments. However, there is little evidence of firm commitment to realise this high ideal in practice and even the Strategy's promise that a Population Health Division would be established in the Department of Health and Children has not been fulfilled.

- The adoption of a population health focus in service provision. This would entail the provision of free population screening programmes in all parts of the country, which would be well integrated with primary care; the overall development of primary care so it could, for example, implement a range of health education and promotion initiatives, including those directed towards the needs of high-risk groups; making primary care free at the point of delivery to an increasing proportion, and ultimately all, of the population; the radical improvement of mental health care services.

- The reduction and ultimate elimination of inequity in access to hospital in-patient and outpatient care and in the quality of care received.

- The implementation of effective measures to address the threats to health arising from smoking, alcohol and substance abuse, and obesity. While the Irish health system has adopted an active and progressive approach to reducing the harm caused by smoking, the same cannot be said with regard to the other health risks mentioned.

Research findings have repeatedly shown Ireland as having extremely unhealthy levels and patterns of alcohol consumption, including the worst incidence of binge drinking in Europe, with consequent detrimental effects on health.[64] Yet no serious or concerted efforts have been made

to adopt the measures which international evidence indicates can be effective in reducing hazardous and harmful drinking – limiting availability, raising prices and restricting marketing – a failure which in part reflects the fact that the drinks industry has been allowed to influence policy in this area. The Second Report of the Task Force on Alcohol, published in September 2004, set out a wide range of recommendations but so far no action plan to ensure their implementation has been published by the Department of Health and Children.

While a National Drugs Strategy has been in place since 2001, the problem of illegal drug use is increasing and is now present in all parts of the country; there are serious deficiencies in all four categories of services needed to address drug problems – detox, treatment, rehabilitation and after care.

The Report of the Task Force on Obesity highlighted the fact that 29 per cent of the adult population is overweight and 18 per cent obese, and estimated that as many as 300,000 Irish children are overweight or obese.[65] The Report put forward a range of recommendations, including a number in relation to action at central governmental level. A National Nutrition Policy has been promised but two years on from the publication of the Task Force's Report no agency has been charged with responsibility for ensuring that the recommendations across all the sectors identified are actually implemented.

4.5 Accountability and Participation

The importance of accountability and participation

Given the vital importance of health services and the impact they may have on people's lives, and given also the scale of public expenditure on these services, it is critically important that adequate structures and systems should be in place to ensure public accountability and democratic participation in relation to health policy.

Beyond these fundamental reasons for accountability and participation, however, there are strong grounds for arguing that the effective engagement of a wide range of people in the shaping, governance and monitoring of services is beneficial in the difficult task of improving health care provision. Such engagement can help the development of more appropriate, more accessible, and responsive services. It can also help to facilitate greater awareness of the complex realities of health service provision, increase service providers' consciousness of the need for accountability, enhance public confidence in the system, and increase appreciation of the need for continued investment of public funds if services are to improve.

Moreover, mechanisms for the engagement and participation of the public are critical to achieving improved health outcomes: such mechanisms provide a means of fostering public awareness, understanding and acceptance of the measures needed to address the health risking behaviours and the social and economic inequalities that are such important influences on health status.

A weak system for accountability and participation

The 2001 Health Strategy included as part of its 'new vision' for the Irish health care system a promise that this would be: 'A health system that encourages you to have your say, listens to you, and ensures your views are taken into account.' A core principle guiding the Strategy was to be 'people-centredness' and the Strategy's Action Plan said that: 'Provision will be made for the participation of the community in decisions about the delivery of health and social services.'[66]

Despite this commitment, and despite various official statements on the importance of enhancing active citizen engagement in public services provision (reflected in, for example, the Partnership Agreement, *Towards 2016*, the reports of partnership bodies, such as the National Economic and Social Council and the National Economic and Social Forum, and the establishment of the Taskforce on Active Citizenship[67]), the 'democratic deficit' in the Irish health system has if anything increased. The abolition of the health boards in 2004 removed the last vestiges of local democratic accountability for the health system and the creation of the Health Service Executive (HSE) has resulted in a highly centralised structure for the development and implementation of health services.

The Minister for Health and Children and his or her Department has responsibility for the formulation of health policy, and the Minister has ultimate political responsibility for the health services, both public and private. The HSE has responsibility for the management and delivery of the public health services. However, the Minister has considerable powers in relation to the operation of public services, having, for example, the power to issue written directives to the HSE with which it must comply. The policy–operations divide between the Minister and the HSE leaves scope for confusion and for shifting of responsibility, so that, for example, a Minister could distance him or herself from politically sensitive decisions, such as the closure of hospitals, with the argument that these are 'operational' matters and, therefore, the responsibility of the HSE. The Minister has sole authority for the appointment of members to the Board of the HSE; no specific criteria are laid down for the selection of members or for the ultimate composition of the Board and there is no provision for including direct representatives of the public, service users or staff.

Funds for the implementation of health services are voted directly to the HSE yet there are only weak mechanisms for holding the HSE accountable to the Oireachtas. For example, the answering of Oireachtas members' questions about the HSE should be a key element in ensuring democratic accountability. However, the regulations governing the answering of questions seem to suggest that such questions are of no greater status than those from other sources and the regulations do not require that the answers to such questions should be published.[68]

Part 8 of the Health Act 2004 provides for 'Public Representation and User Participation'. This includes the convening by the Minister of a 'National Health Consultative Forum'. The first such Forum under the Act was held in October 2006, and brought together for a one-day meeting over 300 participants, at the invitation of the Minister, from within the HSE, the Department of Health and Children and other government departments, voluntary and professional bodies, trade unions, and patient and client groups. There is clearly value in the exchange of information and the cross-sector dialogue of such a meeting, and in the publication of a report on the proceedings,[69] but beyond this it is not apparent how precisely this Forum can be shown to have a real influence on the development of health policy, much less be a 'mechanism which could hold the health care system or the political system to account'.[70]

The Health Act also provides for the establishment of four Regional Health Forums, composed of elected members of local authorities. However, they do not have the power to require national or regional officials of the HSE to attend their meetings to respond to concerns.[71] Under the Act also, the HSE is enabled to establish advisory panels, involving potential service users as well as representative organisations. The HSE has the right to determine the terms of reference, membership, rules and procedures for each panel. Some panels were established during 2006. In its Report on *Improving the Delivery of Quality Public Services*, the National Economic Social Forum noted: 'there is some lack of clarity on the impact of these panels on the development and delivery of services.'[72]

5. Theological Reflection

Christianity is a faith that values materiality and the integral connection between body, mind and spirit – even if historically this has not always been the dominant operative note resonating in the Christian psyche. But the biblical roots for this holistic approach are unmistakable: the creation that God saw was good, with the human person's inviolable dignity grounded in being the image and likeness of God's own self; the astounding and mysterious taking by God of bodily, human existence in the Incarnation; the practice of Jesus in healing and curing sickness of mind and body, laying on of hands, using spittle and clay; the Church as the Body of Christ, with the Eucharistic body and blood as the core of a sacramental system which finds God in all things, above all in the neighbour; and of course the bodily resurrection of Jesus, our promised ultimate destiny also.

This positive view of the body is set in a realistic context: people get sick, in body, mind and spirit; they suffer. And if sickness is due to some primordial disorder in our world, this is not to be confused with personal sin or inherited guilt: 'Rabbi, who sinned, this man or his parents, for him to have been born blind?' 'Neither he nor his parents sinned', Jesus answered (Jn. 9: 1–2). It is also true that sickness – and even death itself – is not ultimately tragic, that in the Christian dispensation we believe that nothing is wasted, that 'unearned suffering is redemptive' (Martin Luther King), that in sickness and death we are close to the paschal experience of Jesus Christ so that we too can say: 'It makes me happy to suffer for you, as I am suffering now, and in my own body to do what I can to make up all that has still to be undergone by Christ for the sake of his body, the Church' (Col. 1: 24–25). There is, then, meaning in illness, including illness that is terminal.

However, just as Jesus was in no hurry to set his face to Jerusalem, Christianity does not glorify death and suffering but is, rather, life-affirming. And so Jesus makes it clear that he wants us to have life, to the full (Jn. 10:10), and one of the signs of the Kingdom that he announces is that people are cured of sickness, that 'the blind see again, the lame walk, lepers are cleansed, and the deaf hear …'(Lk. 7: 21–22). He has enormous compassion for the sick of mind and body, goes out of his way to minister to them, breaks taboos to do so (his contact with lepers, his healing on the Sabbath). This is the face of God, the will and dream of God, the 'heart which sees'.[73]

And, tellingly, but completely consistent with his more general attitude towards the person who is poor, the stranger, the foreigner, this healing care is not just for 'his own'. There is an interesting illustration of this in a humorous, at times almost caustic, exchange with the Canaanite (Mt. 15: 21–28) or Syrophoenician (Mk. 7: 24–30) woman who wanted Jesus to cure her daughter. Jesus reminds the woman of the conventional wisdom that he had in fact come for 'his own', that she did not qualify for his help, that 'the children should be fed first, that it is not fair to take the children's food and throw it to the house-dogs'. Nothing daunted, and with only one thing on her mind (to alleviate her daughter's suffering), the woman retorts: 'Ah yes, sir … but the house-dogs under the table can eat the children's scraps'. Jesus then cures her daughter.

Through exchanges such as this, Jesus himself and then the early Church realised that the Kingdom was for all, and that the poor, the sick, the outcast, the foreigner have in fact a privileged, not a concessionary, place. And so the directness and almost shocking brutality of this exchange can encourage us: we too need to be shocked out of a complacency which has allowed us to tolerate the injustices of our health service and to yield to the temptation to give people who are less well-off only the scraps from the master's table.

We know what it is like to want the best for our own children, especially when they are ill: the maternal and paternal heart of God wants no less for all of us, rich and poor alike. God relies on us to bring this about in the area of health with the care, excellence, justice and freedom which correspond to the divine dream for our world and which entail appropriate personal and interpersonal qualities and formation, but also institutional and structural provisions. Such is the logic of the Incarnation, the faith vision behind the vision and values which we can also adopt on simple grounds of rationality and appeal to goodwill.

6. Conclusion

We have noted that, at first sight, our vision and set of values appear relatively uncontroversial. Yet when they are used to assess the present reality of the Irish health care system they lead to very challenging conclusions.

The vision and values set out support present aspirations towards a first-class health service, while challenging those who argue that this can be achieved without funding that is equal to or greater than that now allocated, even allowing for necessary further economies, efficiencies and accountability. Thankfully, with our newly achieved affluence, we have the means as a country to provide an excellent health service for all. We need, however, to commit ourselves to this goal. Politicians need to give the lead in this, to persuade us to realise the social dividend of our economic boom.

Next, given the vision and value of providing this service to all on the basis of need and not ability to pay, there is a strong challenge to Government to radically reduce and eliminate the inequity which characterises our health system. We have argued that despite rhetoric to the contrary – because all will say they want justice, want equity – the operative logic of health policy in recent years, with its favouring of private sector provision, would seem to lead to greater inequity. Instead, we urge that Government focuses on the provision of an excellent public health service that is available to all who need it.

The challenge here is not just to politicians – it is also to vested interests within the medical and other professions and to the general public, over 50 per cent of whom have invested in private health insurance.

It is not too late to redress the current situation, but where will the leadership emerge which might, over time, restructure our system so that invidious and scandalous distinctions in matters of health, of life and death, are eliminated? The challenges inherent in radically reforming our health service will be met only through building social solidarity among all citizens so that there emerges a willingness to adopt, and fund, policies that will serve the common good.

We have noted that technical excellence and justice need to be complemented by an ethos of care which has regard for the whole person at a time of suffering and stress.

No parent would stand idly by while a child suffers from illness. God, our Mother and Father, our Creator, feels the same way, and even more so. We in Ireland as a people and as a State have an opportunity to create something wonderful – excellent, just, caring, accountable – out of our currently under-resourced and inequitably structured health service. We will do so only if we have a clear vision of what we want. Let us step back from treating health care as a commodity, to look at the bigger picture, to redefine what it is we want, and then to pursue it with all the commitment and problem-solving capacities at our disposal.

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3   Department of Health and Children, *Quality and Fairness: A Health System for You – Health Strategy*, Dublin: Stationery Office, 2001, Action Points, 79 and 81.

4   Accountants Deloitte and Touche, commissioned by the Department of Health and Children in 2001 to study value for money in the health service, championed this need to identify values as a precondition for knowing what we wanted and therefore how we should spend our money. (Maev-Ann Wren, *An Unhealthy State*, p. 239)

5   See, for example, Rawls; Habermas.

6   *The Health for All Policy Framework for the WHO European Region: 2005 Update* (Regional Committee for Europe, Fifty-fifth session, Bucharest, Romania, 12–15 September 2005), par. 33. (www.euro.who.int)

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10   See for example, Pope John Paul II, *Centesimus Annus* (The Hundredth Anniversary), Encyclical Letter, 1 May 1991, n. 34.

11   Irish Commission for Justice and Peace, *Re-righting the Constitution*, 1998, Dublin: Irish Commission for Justice and Peace, IX, 7.

12   Pope John Paul II, *Centesimus Annus*, n. 40.

13   Fergus O'Ferrall, *op. cit.*, p. 276.

14   It is well illustrated in Pope Benedict's presentation of the relationship between love and justice in *Deus Caritas Est* (God is Love), Encyclical Letter, 25 December 2005.

15   Pope Benedict XI, *Deus Caritas Est* (God is Love).

16   *Quality and Fairness: A Health System for You – Health Strategy*, p. 17.

17   In Catholic social teaching the achievement of justice is closely related to the principle of solidarity (cf. Pope John Paul II, *Sollicitudo Rei Socialis* (On Social Concern), Encyclical Letter, 30 December 1987, n. 74–5).

18   In particular, the work of Habermas and of Rawls; Catholic social teaching; the concept of civic republicanism. The Background Working Paper which accompanied the Report of the Taskforce on Active Citizenship provides a valuable outline of the concept of civic republicanism (*The Concept of Active Citizenship*, Background Working Paper, Dublin: Task Force on Active Citizenship, 2007). See also Iseult Honohan, *Civic Republicanism*, London: Routledge, 2002.

19   This much is acknowledged in a General Comment by the UN Committee on Economic, Social and Cultural Rights on the right to health as expressed in the International Covenant on Economic, Social and Cultural Rights: '... in terms of political and economic systems the Covenant is neutral and its principles cannot accurately be described as being predicated exclusively upon the need for, or the desirability of, a socialist or a capitalist system, or a mixed, centrally planned, or laissez-faire economy, or upon any other particular approach.' (General Comment No. 14: The Right to the Highest Attainable Standard of Health, 2000)

20   Rawls.

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