



## CARING FOR HEALTH IN IRELAND

The Council for Justice and Peace  
of the Irish Episcopal Conference



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## EXECUTIVE SUMMARY

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1. Conscious of the importance of health and health care to all members of our society, particularly during a time of economic crisis, the Council for Justice and Peace has prepared a response to the plans for health care reform outlined in the *Programme for Government*. This response is inspired by key principles from Catholic Social Teaching – **human dignity, the common good, participation, solidarity and subsidiarity** – and has been developed in consultation with Catholic health service providers.
2. The lack of focus on the **public health outcomes** that health policy should aim to achieve is an important gap in the *Programme for Government*. The public health strategy which the Department of Health is developing at present may help to fill this gap. In the meantime it is a concern that the commitments on health service reform contained in the *Programme for Government* refer mainly to health service inputs and say little about the improved public health outcomes which the reforms are expected to achieve. The government's commitments thus lack an outcomes-oriented framework within which difficult choices about resource allocation and service planning in the health services might be made.
3. In Ireland today, the less well-off are still more likely to experience ill health and die younger than those with higher incomes and do so because of a wide range of **social determinants of health**. The *Programme for Government* says little about these social determinants and the measures that might be taken to address them.



4. While concerned about gaps in the government's commitments on health, the Council also acknowledges that the *Programme for Government* tackles real and serious issues of **equity and efficiency in the health services**. The Council supports the core aim of the reforms set out by the government in these areas: to make health services fairer and more efficient. The commitment to equity, social justice and a funding system based on social solidarity in the government's proposals is to be especially welcomed.
5. Reducing excessive use of hospital services by developing stronger primary care and post-hospital services has long been a goal of health policy. The Council welcomes the government's pledge to deliver on this goal and regards the measures proposed as being capable of enhancing **subsidiarity in the health care system**. The Council also welcomes proposals to reform the present two-tier system of health care through the introduction of a **Universal Health Insurance scheme** and notes that Catholic service providers also see these proposals as positive developments. While the Council supports the general thrust of these reforms, it also points to risks of generating new forms of inequity which they entail and emphasises the need for careful design and monitoring to ensure that these risks do not materialise.
6. The need for clearly defined outcomes is also apparent in relation to **Mental Health Services**. The Council for Justice and Peace welcomes proposals aimed at reducing inequities in access to mental health services and highlights the need for a strong system of evaluation and accountability.
7. **Disability** is now rightly treated within the framework of human rights, rather than a medical model of diagnosis and care. There is a need for further examination of how funding allocation impacts on service provision in this area.
8. Where institutional care is absolutely necessary for **older people**, this should be provided to the highest possible standard. Older people

should not, however, be compelled to enter institutions as a result of a lack of suitable alternatives, such as community based care and home services.

9. **Palliative Care** is a field where services provided by Catholic providers play a prominent role. Here, the typical medical concern with therapy becomes less relevant and the focus shifts instead to the medical, social and psychological supports needed to ease the passage through the final stages of life.
10. The Council for Justice and Peace believes that the proposals for reform of the health care system, outlined in the *Programme for Government*, represent a serious attempt to rectify major problems of inequity and inefficiency in Irish health services. The **impact of the reforms** will depend on the detail of their design. Further debate and reflection is needed to ensure that the commitment to social solidarity and efficiency be sustained and carried through into the ultimate goal of continued improvement in health in all sectors of Irish society.

## FOREWORD

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It is in care for the sick more than any other way that love is made concrete and a witness of hope in the Resurrection is offered.

Message of His Holiness John Paul II for the Eleventh World Day of the Sick, 2003<sup>1</sup>

*Caring for Health in Ireland* was the title chosen for this position paper from the Council for Justice and Peace of the Irish Episcopal Conference, and this title clearly reflects what should be our primary objective: to empower people to care for their health. In a climate of economic crisis, health care – an area in which the need for reform was widely recognised prior to the crisis – has come under increasing pressure. As household and personal incomes fall, it can become more difficult to prioritise health and maintain a healthy lifestyle. At the same time, the stress experienced by people as a result of the present economic climate can have a negative impact on their health – both physical and mental – and/or cause them to seek relief through behaviour which threatens their health, such as smoking, drinking alcohol and taking drugs.

With health-related issues giving such cause for concern, it is encouraging that health care reform features prominently in the current *Programme for Government*. The central argument of the present paper, however, is that this reform, necessary though it may be, will only be successful to the extent that it succeeds in defining clearly the outcomes it seeks to achieve in terms of public health. In its approach to this issue, the Council for Justice and Peace takes inspiration from the Social Teaching of the Catholic Church. This gives it a person-centred approach, based on the dignity of the human person. We cannot forget that the reason health care is so important is

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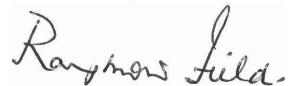
<sup>1</sup> [www.vatican.va](http://www.vatican.va)

because it affects every single person in our society. It is therefore central to the common good and, consequently, any proposals for reform need to be carefully assessed to ensure that everyone in our society will be encouraged and supported in caring for his or her health.

This paper has been developed in consultation with Catholic religious congregations involved in health care provision in Ireland. The Catholic Church in this country has a long history of following the example of Jesus in caring for the poor and the sick: ‘As long as you do this to the least of my brothers and sisters, you do it to me’ (Mt 25:40).

Sadly, it must be acknowledged that some individuals who were involved in this work in the past went against that example and perpetrated abuse against vulnerable individuals in their care. The vast majority, however, were and are generous individuals who selflessly devote themselves to caring for the sick and for those who suffer in body, mind or spirit. Catholic providers continue to make a significant contribution to health care provision in Ireland today and their encouragement, participation and contribution to this position paper from the Council for Justice and Peace is an indication of their readiness and desire to be part of the dialogue on reform.

I would like to thank the members of the Council for Justice and Peace and its predecessor, the Irish Commission for Justice and Social Affairs, for their work on this issue. Particular thanks are due to Professor Tony Fahey, University College Dublin, who led the research for this paper; to the experts and commentators on health care reform who contributed; and the leaders of the participating religious congregations (listed in the appendix). It is our hope that this paper will help to keep the values of human dignity and the common good at the heart of this debate, now and in the future.

A handwritten signature in black ink that reads "Raymond Field". The signature is written in a cursive, flowing style.

*Bishop Raymond Field*  
Chair, Council for Justice and Peace  
of the Irish Episcopal Conference

## INTRODUCTION

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Life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the needs of the common good.

*Catechism of the Catholic Church, no. 2288*

The government set out ambitious plans to reform the health services in the *Programme for Government* adopted in the aftermath of the general election of February 2011.<sup>2</sup> In this document, the Council for Justice and Peace comments on these plans from the perspective of Catholic social teaching and in light of the role played in the health services by Catholic health service providers. The Council believes that core principles on health derived from Catholic Social Teaching (see box overleaf) provide a valuable vantage point from which to offer such commentary and also that Catholic thinking on health and health policy can benefit from engaging with the challenges faced by health policy in Ireland today. In addition, Catholic religious congregations have long played an important role in providing health services, and the significance of the reforms for their role needs to be considered. To that end, the present document seeks to take account of the circumstances and views of Catholic health service providers and integrate them into an overall Catholic perspective on current health issues.<sup>3</sup>

Health issues are important to everyone because of the influence of health in terms of our ability to participate in society and achieve our potential. In a time of economic crisis, pressures on the health system become increasingly evident and it is more important than ever that the government

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<sup>2</sup> *Programme for Government 2011*, [www.taioseach.gov.ie](http://www.taioseach.gov.ie)

<sup>3</sup> For a list of Catholic health service providers who were consulted in the preparation of the present document, see Appendix 1.

does all it can to incentivise people to care for their health and facilitate their access to the highest possible standard of care in times of ill health. Our approach to health care reform needs to be person-centred, as the experience of being ill and/or requiring treatment can leave people feeling vulnerable. Investing in health means investing in people and investing in the future of our nation. That future should be based on the recognition of the dignity of every human person and the promotion of the common good in society.

#### **Catholic Social Teaching on Health – Core Principles<sup>4</sup>**

*The Dignity of the Human Person:* Created in the image of God, the human person is not just something, but someone. We believe that each human person has been addressed by God and invited to share in the ‘great hope that sustains the whole of life’ (Pope Benedict XVI, *Spe Salvi*, 27). This is the foundation on which all human rights rest. Catholic Social Teaching has long recognised the right of people to the means necessary for the protection of their health and access to health care in times of ill health.

*The Common Good:* Stemming from our recognition of the dignity, unity and equality of all people, the common good is the sum total of conditions which allow everyone to achieve his/her potential. Political leaders have a particular responsibility to promote the common good, which is person-centred in nature: ‘The common good of society is not an end in itself; it has value only in reference to attaining the ultimate ends of the person and the universal common good of the whole of creation’ (*Compendium*, no. 170). Health issues – which affect every single person in our society – are necessarily at the heart of the common good.

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<sup>4</sup> For a detailed examination of these principles see: Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, Dublin: Veritas, 2004, pp. 79–94. Hereafter *Compendium*.

*Participation:* The duty to contribute to the cultural, economic, political and social life of the civil community to which we belong, with a view to the common good. A person's health status can have a determinative impact on his or her ability to participate in society.

*Solidarity:* Recognising the intrinsic social nature of human beings and the interdependent nature of our relationships with others, the principle of solidarity compels us to work to eliminate injustices, on both a personal and institutional level. As Pope John Paul II reminds us, solidarity is not 'a vague feeling of compassion' but 'a firm and persevering determination to commit oneself to the common good' (*Solicitudo Rei Socialis*). In the area of health care, solidarity compels us to contribute all we can to ease the suffering of others.

*Subsidiarity:* Respect for the dignity of the person needs to extend to the social groupings people form within our society. The state has an obligation to respect these groups, supporting their participation in decisions that affect them and protecting them from unjust interference at a higher level that would constitute a threat to freedom. Our approach to health care reform needs to be person-centred, taking account of the views of those working in our health services, and the people who depend on them.

## PUBLIC HEALTH – THE ULTIMATE OBJECTIVE

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Concern for the health of its citizens requires that society help in the attainment of living conditions that allow them to grow and reach maturity: food and clothing, housing, health care, basic education, employment and social assistance.

*Catechism of the Catholic Church, no. 2288*

A notable feature of the section on health in the *Programme for Government* is that it deals with health services, not health. At times in the past in Ireland, it was clear what improvements in public health were expected of health policy – for example, eradicating TB or reducing infant mortality. The *Programme for Government* identifies no similar health challenges facing health policy today, nor does it define the gains in public health that reforms in health policy should be designed to achieve. Its focus on the health services means that it talks of inputs to the health system rather than outcomes in the form of a healthier population. Attention to inputs is important, but it needs to be disciplined by constant assessment of what does and does not work in making people healthier.

The Department of Health is currently developing a public health strategy to cover the period 2012–2020 and has conducted a wide-ranging public consultation in order to inform that strategy. A report on that consultation contains a welcome acknowledgement of the need for health policy to be oriented to health rather than health services and of the many social and lifestyle factors, ranging from poor education and low incomes to smoking and lack of exercise, that influence health.<sup>5</sup> A vigorous strategy

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<sup>5</sup> *Proceedings of the Public Health Policy Consultation, June 2011*, Department of Health and Institute of Public Health, n.d.



to combat the existing over-medicalisation of health policy and tackle these social factors could deliver major benefits for public health, and the Council therefore strongly supports the Government's initiative in this area. It believes in particular that it is only within an integrated approach to medical and social interventions to promote health that difficult questions about resource allocation between these broad approaches and between different activities within each approach can be rationally resolved. Demand for medical services is likely to be more forceful and vocal than demand for effective interventions to tackle the social determinants of health, even where social interventions are likely to deliver the greater health benefits. The public health strategy should therefore not only spell out goals for public health but also set out the role that each major field of intervention is expected to perform in achieving those goals, the implications for resource allocation that arise from such roles and the mechanisms that will be used to ensure that spending actually goes to the areas where it will achieve greatest benefit. Such an approach requires that public opinion be educated on the imperative of controlling expenditure on high-tech, high-cost hospital services in order to free up resources for interventions which can deliver real health benefits by other means. A recent OECD review of the public sector in Ireland has identified the lack of such an orientation to **performance** – that is, to ultimate gains achieved rather than activities carried out or services provided – as a key weakness in Irish public services.<sup>6</sup> The focus on health inputs in the *Programme for Government* reflects such a weakness. The Council hopes that the public health strategy now being developed by government will rectify that weakness and will place the outcomes expected of medical as well as social interventions to promote health at the centre of attention.

Health policy needs to be more specific about the improvements in public health it seeks to achieve and the contributions that major areas of intervention, both medical and social, are expected to make to such improvements. It is only on that basis that a rational approach to designing and funding health services can be fully developed.

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<sup>6</sup> OECD, *Ireland: Towards an Integrated Public Service*, Paris: OECD, 2008.

One consequence of the lack of attention to performance in the *Programme for Government* is its silence on the remarkably positive trend in public health found in Ireland in recent years and the context that might provide for setting new health goals. Since 1999, the age-standardised death rate in Ireland has fallen by almost one-third. While this decline has occurred over a wide range of causes of death, a large reduction in deaths from circulatory diseases (mainly heart attacks and strokes) has been the main contributor. Deaths from these diseases fell by 43 per cent between 1999 and 2008. These are extraordinary advances: they achieved in a single decade as much progress in combating premature death as had been made in the previous three decades in Ireland.<sup>7</sup> They also represent the largest advance in Europe over this period and have enabled Ireland to overcome its position as a health-laggard by EU standards. In 1999, age-standardised death rates in Ireland were 22 per cent higher than the average for the EU-15. By 2008, that differential had been eliminated as Irish death rates more or less matched those of the EU-15 average. This decline in death rates means that, according to Eurostat estimates, Irish people gained a remarkable 3.8 years in life expectancy between 1999 and 2008, a gain that was about double that of the EU as a whole for the period. At the same time, new threats to health have emerged, such as the rise in obesity and the rise in alcohol consumption during the economic boom. A health policy aimed at performance would take trends in these and other measures of public health as its primary reference point and would frame its goals in terms of further gains that could be made, while paying particular attention to those areas where progress had been slow and catch-up was possible.

Public health has been on a sharply rising trend in recent times, though new threats to health (such as the rise in obesity) have also emerged. Health policy should take more notice of these trends and identify and act on areas where further progress is possible.

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<sup>7</sup> The age-standardised death rates per 100,000 population in Ireland were 1208.32 in 1970, 837.4 in 1999 and 571.3 in 2008. The decline in the 29 years between 1970 and 1999 was thus 30.7 per cent, compared to a slightly higher decline of 31.8 per cent in the nine years between 1999 and 2008 (data from European Health for All Database – <http://data.euro.who.int/hfad/b/>). For a detailed analysis of trends in Irish mortality rates, see Brendan Walsh, ‘Wealthier and Healthier: Ireland’s Demographic Catch-up’, *Journal of the Statistical and Social Inquiry Society of Ireland*, XXXVII, 2008, pp. 95–111.

Such a focus would also require greater attention to what works in improving health, not just at the level of particular treatments but also in connection with the mix of services that delivers most benefit to the public. Such an evidence-informed approach to planning services is crucial in times of cut-backs in order to avoid the risk of effective services that really improve people's lives being cut back in the same way as those which deliver less benefit. A recent study by the Health Research Board gives cause for concern here, since it finds that although there is now a considerable level of research on public health and health services in Ireland, demand for such research from health policy makers and managers is weak and there is a disconnect between research and policy.<sup>8</sup>

The issue in this context is that health services are but one among a number of contributors to public health and certain areas of the health service are likely to have greater impact than others. A study of the decline in coronary heart disease mortality in Ireland in the period 1985–2000 concluded that 43.6 per cent of the decline was due to medical treatment and 48.1 per cent to lifestyle changes, such as reduced smoking and better diet (the balance of 8.2 per cent was unattributable).<sup>9</sup> Another study drew a distinction between causes of death that were 'amenable' to medical treatment and those that were 'non-amenable'. It pointed to data showing that half the fall in deaths among those aged under 75 years in Ireland in the years between 1997–98 and 2002–03 were due to declines in 'amenable' causes of death (and thus possibly due to medical treatments) and half to declines in 'non-amenable' causes (which were probably due to other factors).<sup>10</sup>

These indications suggest that a consistent focus on health itself as the ultimate target of health policy would prompt a considerably broader focus in policy debate and development than is reflected in the current preoccupation with health services. It would also prompt a more sustained

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<sup>8</sup> M. Hiney, B. Curran and P. Clarke, *Review of Population Health Research and Health Services Research in Ireland*, Dublin, Health Research Board, 2011.

<sup>9</sup> K. Bennett, Z. Kabir, B. Unal, E. Shelley, J. Critchley, I. Perry, J. Feely, S. Capewell, 'Explaining the Recent Decrease in Coronary Heart Disease Mortality Rates in Ireland, 1985–2000', *Journal of Epidemiology and Community Health* 60, 2006, pp. 322–327.

<sup>10</sup> B. Walsh, 'Wealthier and Healthier: Ireland's Demographic Catch-up', *Journal of the Statistical and Social Inquiry Society of Ireland*, XXXVII, 2008, pp. 95–111.

and searching approach to evaluating the benefits of services and to taking account of such information in planning reforms and in making the difficult decisions on service cutbacks that are now faced by government.

Health policy should adopt a comprehensive concern for social as well as medical influences on health and should pay more attention to evidence on what works in planning reforms of the health services.

From a social justice perspective, concerns with outcomes point particularly to the problem of inequalities in health and the impact of wider social inequalities on health. The goal of reducing differentials in health by socio-economic status (SES) is often ranked alongside the goal of overall improvement in health as an overarching objective of health policy. In Ireland, disparities in health across social classes and other social categories continue to be wide: the less well-off have more illness and die younger than the better off.<sup>11</sup> However, SES differences in health are highly durable over time and place. Even though the mechanisms linking low socio-economic status to poor health may change, social inequality remains as a ‘fundamental cause’ (high rates of smoking and unhealthy eating among lower SES groups, for example, now play the role as a cause of health differences formerly occupied by poor sanitation or lack of access to medical care).<sup>12</sup> A successful formula for reducing such differences has yet to be found.

Strong welfare states, however beneficial in other ways, have had little success in reducing health inequalities. Comparative research in Europe suggests that the best health and narrowest health inequalities are found in Mediterranean countries such as Spain and Italy, which are relatively unequal in other ways, while the Nordic countries, with their strong commitment to social justice, have SES gradients in health that are similar

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<sup>11</sup> Central Statistics Office, ‘Mortality Differentials in Ireland’, *Statistical Release*, December 2010; S. Burke and S. Pentony, *Eliminating Health Inequalities: A Matter of Life and Death*, Dublin: TASC, 2011. C. Farrell, H. McAvoy, J. Wilde, *Tackling Health Inequalities – An All-Ireland Approach to Social Determinants*, Dublin: Combat Poverty Agency/Institute of Public Health in Ireland, 2008.

<sup>12</sup> J. C. Phelan, B. G. Link and P. Tehranifar, ‘Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications’, *Journal of Health and Social Behavior* 51(S), 2010, S28–S40.

to those of less egalitarian states in Northern and Western Europe.<sup>13</sup> Although Ireland has not been included in this research, the broad indications are that mortality differentials in Ireland seem to be of a similar order to those in the Nordic countries, despite the higher levels of social inequality and weaker systems of social provision found in Ireland.<sup>14</sup> Recent arguments in international research that income inequality is a significant influence<sup>15</sup> have attracted wide media attention, but evidence on this question is weak and inconsistent.<sup>16</sup>

One possible explanation for the persistence of SES differences in health is the faster adoption of new behaviours and technologies that support health among the better educated: they are always likely to be first off the mark in learning about and taking on whatever the latest step forward in the pursuit of better health is, whether this has to do with quitting smoking, taking exercise or accessing new medical treatments.<sup>17</sup> Such innovations may eventually filter down to the less well-off and achieve similar health benefits, but by then the better-off, like the front carriages in a forward-moving train, have progressed on to the next horizon and so preserve their relative advantage.

Inequalities in education are an important element in this enduring arrangement.<sup>18</sup> So it is likely that, in Ireland, as well as tackling proximate sources of unequal health such as smoking, diet and access to effective medical treatments, an attack on educational disadvantage may be an

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<sup>13</sup> J. Mackenbach, I. Stirbu, M. A.-J. R. Roskam, M. M. Schaap, G. Menvielle, M. Leinsalu and A. E. Kunst, 'Socioeconomic Inequalities in Health in 22 European Countries', *New England Journal of Medicine* 358, 2008, pp. 2468–81.

<sup>14</sup> Thus, for example, Mackenbach et al. (n. 13 above) report an approximate two-fold differential in death rates between the highest and lowest educational categories in the Nordic countries. The CSO (n. 10) report a similar differential for Ireland.

<sup>15</sup> Presented especially in R. Wilkinson and K. Pickett, *The Spirit Level: Why More Equal Societies Almost Always Do Better*, London: Allen Lane, 2009, pp. 73–87.

<sup>16</sup> N. Kondo, G. Sembajwe, I. Kawachi, R. M. van Dam, S. V. Subramanian and Z. Yamagata, 'Income Inequality, Mortality, and Self-Rated Health: Meta-analysis of Multilevel Studies', *BMJ*, 339:b4471, doi: 10.1136/bmj.b4471, 2009; D. Cutler, A. Deaton and A. Lleras-Muney, 'The Determinants Of Mortality', *Journal of Economic Perspectives* 20:3, 2006, pp. 97–120.

<sup>17</sup> See Phelan et al. (n. 12 above).

<sup>18</sup> D. M. Cutler and A. Lleras-Muney, 'Understanding Differences in Health Behaviours by Education', *Journal of Health Economics* 29, 2010, pp. 1–28.

important indirect route to reduction in health inequalities and might be particularly effective if targeted during the early years of life.

The reduction of social inequalities in health should be a core target of health policy and should be seen as an important component of the reduction of social inequalities more generally.

## EQUITY IN HEALTH SERVICES – THE CHALLENGE OF SOLIDARITY

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‘ [Solidarity] is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is a firm and persevering determination to commit oneself to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all. ’

Pope John Paul II, *Sollicitudo Rei Socialis*, 1987<sup>19</sup>

Although the section on health in the *Programme for Government* is insufficiently oriented to public health outcomes, the problems in the health services that it sets out to tackle are real and in need of urgent action. The stated core aim of the reforms in the *Programme for Government* is to make the health services both fairer and more efficient. The Council welcomes the general thrust of this aim, while recognising that the impact of the government’s proposals will depend on the details of design and implementation. Nevertheless, even in their present highly general form, the Council commends these plans as a serious and timely response to the inadequacies and inequities in the Irish health care system.<sup>20</sup>

The Council notes, in particular, the commitment to overcome existing inequities in the health services by introducing ‘a single-tier health service

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<sup>19</sup> [www.vatican.va](http://www.vatican.va)

<sup>20</sup> M. A. Wren, *Unhealthy State: Anatomy of a Sick Society*, Dublin: New Island, 2003; A. D. Tussing and M. A. Wren, *How Ireland Cares: The Case for Health Care Reform*, Dublin: New Island, 2006; The Adelaide Hospital Society & The Jesuit Centre for Faith and Justice, *The Irish Health Service: Vision, Values, Reality*, Dublin: The Adelaide Hospital Society & The Jesuit Centre for Faith and Justice, 2007; S. Burke, *Irish Apartheid: Healthcare Inequality in Ireland*, Dublin: New Island, 2009.

which guarantees access to medical care based on need, not income'. The Council does not adopt a position on the technical merits of the mechanisms the government proposes to achieve this end – the introduction of a scheme of Universal Health Insurance to fund hospital care and the gradual phasing in of a tax-financed scheme of Universal Primary Care which will remove user fees for GP services. However, the Council endorses the overall commitment to equity embodied in these proposals and welcomes in particular the government's pledge that 'Universal Health Insurance will be designed according to the European principle of social solidarity', meaning that 'access will be according to need and payment will be according to ability to pay'.

Catholic Social Teaching underlines that access to health care and the means necessary for the promotion of good health is a basic human right, as expressed by Pope John XXIII in his encyclical letter *Pacem in Terris* (1963): 'Every human being has the right to life, to bodily integrity, and to the means which are suitable for the proper development of life; these are primarily food, clothing, shelter, rest, medical care, and finally the necessary social services'.<sup>21</sup> As the details of reform are worked out and implemented, it is vital that the commitments to social justice contained in these pledges remain intact and are realised as a strong and durable foundation for health care in Ireland.

The Council welcomes the commitment in the *Programme for Government* to introduce a single-tier health service which guarantees access to medical care based on need, not income, and a funding system based on the principle of social solidarity.

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<sup>21</sup> Pope John XXIII, *Pacem in Terris*, 1963, no. 11, [www.vatican.va](http://www.vatican.va)



## EFFICIENCIES IN HEALTH CARE: THE CHALLENGE OF SUBSIDIARITY

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“ We do not need a state which regulates and controls everything, but a state which, in accordance with the principle of subsidiarity, generously acknowledges and supports initiatives arising from the different social forces and combines spontaneity with closeness to those in need. ”

Pope Benedict XVI, *Deus Caritas Est*, 2005

The Council recognises that equity and social solidarity in the health services are not enough, since equal access to a system that makes poor use of scarce resources or provides inferior care is of limited benefit. As outlined earlier, plans to reform health care need to be embedded in a clearly stated framework of public health objectives and clearly articulated evidence on what works in pursuing those objectives. Yet, even within the limits of existing understanding on these issues, it is evident that there are aspects of the health services that cause obvious problems that warrant being tackled immediately.

### *Over-hospitalisation*

Much of the concern with inefficiency in the health care system focuses on the acute hospital sector. A long-recognised problem here is the over-utilisation of expensive hospital facilities because of inadequate primary care services in the community and insufficient step-down facilities that would enable patients to move out of hospital following acute treatment. These inadequacies cause many patients to arrive too soon in hospital or to stay longer than their medical treatment requires. Radically enhanced primary care, expanded post-hospital care services, and closer cooperation and smoother transitions between stages of care have long been recognised

as solutions to this problem and have been adopted as objectives of health policy since the 1990s. These objectives are re-affirmed in current government proposals and the Council hopes that overdue implementation will now be successfully delivered.

The Council urges the government to carry through its pledge to implement long-promised improvements in primary care and post-hospital care as means to reduce over-hospitalisation and make therapeutic care more efficient and effective.

### *Structure and Funding of Acute Hospital Sector*

Further efficiency problems within the acute hospital sector arise from aspects of the structure and methods of funding of hospitals themselves. At present, there are 71 acute hospitals in the country, including psychiatric and specialist (such as maternity and orthopaedic) hospitals.<sup>22</sup> These consist of three main categories:

1. 34 public hospitals which are owned, managed and funded by the state.
2. 18 public voluntary hospitals which are owned and managed by non-profit bodies and are funded primarily by the state. The main owners are Catholic religious congregations, along with the Adelaide and Meath Hospital (Tallaght Hospital).
3. 19 private hospitals which receive no direct public funding<sup>23</sup> and derive their income primarily from patient charges, most of which are covered by private health insurance. These may be further divided into non-profit entities operated by Catholic religious congregations, which account for over half of private hospitals, and commercial profit-oriented entities.

These three categories of hospital embody a complex set of overlapping divides: publicly funded hospitals are part publicly and part privately

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<sup>22</sup> For details see A. Brick, A. Nolan, J. O'Reilly and S. Smith, *Resource Allocation, Financing and Sustainability in Health Care: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector*, Vol I, 2010, pp. 217–27.

<sup>23</sup> Public funds reach private hospitals indirectly through the National Treatment Purchase Fund. This was set up in 2002 to enable the public sector to reduce waiting lists for treatment by purchasing services from private hospitals.

owned, while private hospitals are a mix of non-profit and profit-oriented entities. A further complication is that private practice is permitted within public hospitals, both state-owned and voluntary. Typically, in the region of 20–25 per cent of beds in public hospitals are occupied by private patients.<sup>24</sup> This adds a mix of public and private patients to the mix of public and private ownership found in publicly funded hospitals. Preferential access to care enjoyed by private patients in the hospital system as a whole gives that system the overarching two-tier structure that is the main source of inequity in the system.

Of the changes proposed in the *Programme for Government* to rationalise this system, one – the introduction of universal health insurance in order to provide equal access to care – has already been noted. Two further proposed changes are important both in themselves and because of their significance from the perspective of Catholic social doctrine and Catholic service providers.

The first of these is the government’s proposal to universalise a divide between purchaser and provider in the hospital system by converting public hospitals into independent not-for-profit trusts. This proposal, in effect, would lend public hospitals a structurally similar form to that of existing voluntary hospitals in the public system – that is, their ownership and management would be at arm’s length from the state body that funds them, but would retain a non-profit character. The Council believes that this is a welcome development which is not only justifiable on efficiency grounds but is also consistent with the principle of subsidiarity. This is particularly so since it is proposed that the boards of the newly independent public hospitals will have community (along with staff) representation, thus lending them a desirable civil society dimension.

The other plank of reform is a restructuring of the resource allocation system for acute hospitals away from block grants and budgeting based on historic costs and towards payment-by-activity, where ‘money follows the patient’. The Council considers that this proposal too will yield both efficiency benefits and organisational gains in the direction of enhanced subsidiarity, not least for voluntary hospitals. The existing block grant system is experienced by Catholic voluntary hospitals as a major

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<sup>24</sup> Brick et al. (n. 14), p. 224.

impediment to flexible, efficient operation. Payment-by-activity, in contrast, has the potential to enhance operational autonomy while at the same time preserving a basis for necessary accountability.

These reforms also have the potential to eliminate the existing divide between public and private hospitals and between public and private beds in public hospitals, since the dividing line between public and private in these instances is a distinction between block grant funding (which comes from the public purse) and payment for service (which comes from private insurance). The funding of all acute hospitals through payments for service financed under a Universal Health Insurance scheme thus promises to simplify some of the existing structural complexities in the sector. It will lead to a situation where the dominant form of hospital will approximate to existing non-profit private hospitals. Profit-oriented private hospitals are also likely to play a role in the system, but as a small part of the total.

The Council welcomes these developments both on general grounds and because of their implications for Catholic providers (though, as the next section outlines, it also points to risks that these developments entail). While Catholic providers supported the retention of a private element in health care when the present two-tier system was created in the 1950s, they have long since become unhappy on both ethical and practical grounds with how that system has evolved. Ethically, the two-tier system had become inconsistent with the Catholic commitment to social justice and the common good. Practically, Catholic hospitals have felt compelled to rely on the private tier as a means to supplement a rigid and inadequate public funding system. Thus they regard the role of the private segment in the public system as a symptom of a dysfunctional overall funding regime.

### *Risks*

While the Council welcomes the general thrust of the government's proposals on funding of health care, it also recognises that universal provision does not of itself guarantee equality of services for all (as evidenced, for example, by the primary school system, where inequalities between schools is a well recognised problem in spite of the universal state-funded character of the system). In the health services, the provider-purchaser split and payment-by-activity has the potential to improve hospital services, but also entails risks which will have to be guarded

against. Existing direct public management of health services contains certain safeguards for equity, social solidarity and coordination of activity that could easily be lost in a more devolved system. Experience in Ireland has shown that the existing safeguards are ineffective on their own if other aspects of the system militate against fairness and efficiency. However, a system of independent hospitals competing for funding on a payment-by-activity basis could tend to create new inequalities.<sup>25</sup> Such a system could enable some hospitals to pull ahead of others and could set up incentives to cherry-pick patients and maximise activity in order to protect institutional or individual incomes. On the positive side, competitive rivalry between autonomous hospitals could be a force for innovation and improvement in services. On the negative side, the cumulative effect of such rivalry, if extended over time, could be to create a hierarchy of hospitals in which the weaker units would become the preserve of the more vulnerable sections of the population. Current inequalities between patients in access to care could thus be replaced by inequalities between hospitals in levels of resources, leading to new sources of inequity in the system.

The Council accepts that risks such as these are real and points to the overriding principle of social solidarity as a guide for both state and civil society actors. It recognises the right and the duty of public policy to oversee the use of public resources to ensure alignment with that principle. There is abundant knowledge on how that might be done in connection with hospital funding – for example, through population-based mechanisms for spatial and functional allocation of budgets and through careful calibration of the incentives built into budgeting processes.<sup>26</sup> It is also necessary to ensure that funding mechanisms are transparent, so as to ensure that funding goes where it is allocated and is used for its designated purposes.

The Council supports the conversion of state-owned acute hospitals into non-profit trusts and the replacement of block grant funding with a funding system for all hospitals based on payments for service. It regards these developments as consistent with Catholic teaching on subsidiarity and the common good and with the ethical and practical preferences of

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<sup>25</sup> A detailed discussion of these issues is provided in Brick et al. (n. 14 above), especially chapters 2–4.

<sup>26</sup> Brick et al.

Catholic hospitals. It also considers that such reforms may not on their own guarantee equality of services for all as they contain risks of new forms of inequality that should be guarded against by public policy.

### *Mental Health Services*

An important feature of the *Programme for Government* is the attention it devotes to mental health services. Although recognition of mental illness and provision of mental health services have a long history, they have tended to occupy a Cinderella position in the health system and have operated under conditions that would not be accepted in other areas of health care. The Council therefore welcomes the attention given to mental health in the *Programme for Government*. In particular, it supports three important elements of its proposals on mental health services:

1. The inclusion of a range of mental health services as part of the standard insurance package offered under Universal Health Insurance, a proposal which will reduce inequities in access to mental health services.
2. Strengthening of primary care services in mental health by enhancing the development of community mental health teams and services, a proposal which will improve coverage of and access to services.
3. Closing of unsuitable psychiatric institutions and moving patients to community based facilities.

While welcoming these proposals, the Council also highlights the need for a strong system of accountability and evaluation in mental health services. That in turn requires a clear orientation to outcomes and performance, since a clear vision of the gains in the mental health of the population that the mental health services are charged with achieving is the necessary reference point for assessing how effective those services are. The *Programme for Government* does not present such a vision. This is not to say that a rigorous evidence-based orientation to outcomes is easy to define in mental health services, since the science underpinning mental health treatments and the measurement of mental health status is still uncertain in many ways. Nevertheless, the very uncertainty of scientific knowledge

in this area makes it all the more necessary to maintain a vigilant, questioning approach to performance and to cultivate both scientific reflection and public debate on what the mental health services should be expected to achieve.

The Council welcomes the attention given to mental health services in the *Programme for Government*. It supports in particular the proposals to include mental health services under universal health insurance, to strengthen primary care services in mental health, and to further de-institutionalise psychiatric services. As in other areas of health services, however, a clear vision is needed of the public health benefits that the mental health services are expected to deliver. This in turn will require constant evaluation and reflection on the goals and effectiveness of mental health services.

## NEW DIMENSIONS OF HEALTH: PROTECTING HUMAN DIGNITY AND PROMOTING PARTICIPATION

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“ As long as you do this to the least of my brothers and sisters, you do it to me. ”

Matthew 25:40

Alongside developments in population health and health care systems, our conception of what good health entails has also evolved and has thrown up new challenges for health policy. There are also vulnerable groups in the population who were historically dealt with under a medical model of care but who are now regarded as having entitlements or needs that are of a broader social nature and require a more integrated social response. In many countries, these groups are supported by social services provided outside of the health sector, but in Ireland, for historical reasons, they continue primarily to be dealt with under health policy.

### *Disability*

One area where these patterns arise is in connection with disability. Formerly, the response to intellectual and physical disabilities was determined within a medical model of diagnosis and care. Today, the focus is on the right of people with disabilities to social participation and the obligation of society to adapt to their circumstances and include them in its normal processes. Disability thus becomes less of a medical issue than a matter of adaptation of social institutions in fields such as education, employment, income, housing, transport and the provision of supports to enable those with disabilities to participate as fully as possible in society. The *Programme for Government* contains welcome pledges on continued pursuit of this approach, though it remains to be seen how these pledges will be implemented.



Catholic congregations account for over half of specialist services for those with disabilities at present and have strongly supported the re-orientation of services towards social integration. Serving people with disabilities and supporting the fulfilment of their rights in society is an important element of the Catholic social services' mission and is strongly connected to Catholic doctrine on the dignity of the person. The policy issues facing the sector in some respects echo those found in other areas of the health services – for example, the block grant method of funding is as widespread and as problematic for disability services as it is in the hospital sector. The need to reform funding methods is thus as urgent in this sector as in others. The *Programme for Government* touches on an aspect of this issue in its pledge to move a proportion of public spending on disability to a personal budget model, so that people with disabilities or their families have the flexibility to make choices that best suit their needs. It also refers to the inclusion of disability services in the Comprehensive Spending Review. The details of the reforms that will emerge from these actions are unclear.

While some of the problems facing the disability services are paralleled in other areas, the sector also has a number of distinctive features. One is that the public–private split in services that is such a large issue in other areas of health services, is less relevant in disability services – it is largely a publicly-funded domain. Another feature is that the evolution of the frameworks within which the sector operates has not kept pace with the shift towards the deinstitutionalisation of services. In particular, arrangements for staffing and personnel are still strongly shaped by the legacy of the past and have proved difficult to adapt to present purposes in light of national labour legislation and industrial relations practice. One consequence, for example, is that lower-skill functions are often carried out by higher-skill and more costly staff. A more general matter is whether the inclusion of disability services within the health care system is appropriate in light of the problems of low incomes, unsuitable housing, inadequate education and joblessness faced by those with disabilities. Some service providers argue that if disability services have to have a main 'home' in the social services system, it should lie in social protection rather than health, thus highlighting the prominence of low incomes as a concern for this population category.

Support for the rights of people with disabilities is a concern of Catholic Social Teaching and is a major part of the work of Catholic service providers. The question of how much funding is provided for disability services is an urgent question for policy, but how funding is provided and how services are organised are also important and are capable of being addressed even in difficult budgetary conditions. The Council urges that these issues be addressed in ways that support the rights-based approach to disability and take account of the distinctive features of disability services.

### *Older People*

The *Programme for Government* promises to increase funding for the support of older people in the community. The Council believes that, even in times of overall cutbacks, such an increase is both possible and desirable since over-reliance on costly institutional care has been a major form of inefficiency in elder care. While institutional care is absolutely necessary for many categories of older people and should be provided to a high standard, some are compelled to fall back on costly institutional care because of a lack of suitable supports in the home. Greater use of community based care and home services thus has the potential to simultaneously serve the needs of older people more effectively and save money. Important improvements in services in this area have occurred in recent years, particularly with the development of the Home Care Package Scheme since 2006. In current circumstances, the Council believes that continued development of services such as these would be an important means of ‘doing more with less’ and improving the lives of older people.

### *Palliative Care*

A final issue the Council wishes to highlight is the increased appreciation in discussions of health of end-of-life or palliative care for those in the terminal stages of illness. Here, the typical medical concern with therapy becomes less relevant and the focus shifts instead to the medical, social and psychological supports needed to ease the passage through the final stages of life. This too is a field where services provided by Catholic congregations play a prominent role and where a further distinctive expression of the Catholic social service mission can be found.

## CONCLUSIONS

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“ All concern for the sick and suffering is part of the Church’s life and mission. The Church has always understood herself to be charged by Christ with the care of the poor, the weak, the defenseless, the suffering, and those who mourn. This means that, as you alleviate suffering and seek to heal, you also bear witness to the Christian view of suffering and to the meaning of life and death as taught by your Christian faith. ”

Pope John Paul II, Address to Leaders in Catholic Health Care, 1987<sup>27</sup>

Caring for the sick is a very particular instance of the call to care for one another as we would care for Christ. When a person is sick, a relationship is established in which a sick, vulnerable, perhaps frightened human being has entrusted him or herself to another person or group of people. Patients depend on health care professionals for their health, well-being and often their very lives. The proposals on health care in the *Programme for Government* represent an important opportunity to overcome historic problems in Irish health services, in regard both to the equity and effectiveness of the health care system. The Council welcomes the general thrust of these proposals. It considers that they represent a serious attempt to rectify major problems of inequity and inefficiency in Irish health services. Current budgetary problems should sustain rather threaten these reforms, since ‘doing more with less’ seems possible in many health service areas and should give scope to protect and possibly expand services with highest impact.

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<sup>27</sup> [www.vatican.va](http://www.vatican.va)

In certain areas, particularly in hospital services, the Council views the Government's proposals as consistent with Catholic thinking on subsidiarity and as having the potential to ease difficulties and dilemmas created for Catholic hospital providers by the current system. On the negative side, the Council is concerned that the *Programme for Government* has not yet spelled out the benefits to public health that the health services are expected to deliver. The public health strategy for the years 2012–20 offers the opportunity to rectify that gap and set out the health outcomes against which the performance of the health services might be judged. The Council is also aware that the impact of reforms will depend on the details of their design and believes that much debate and reflection is still needed to ensure that the reforms, as delivered, live up to their promise. The Council's concern, therefore, is that the commitment to social solidarity and efficiency be sustained and carried through into the ultimate goal of continued improvement in health in all sectors of Irish society.

## **APPENDIX: CATHOLIC HEALTH CARE PROVIDERS WHO CONTRIBUTED TO THE CONSULTATION BY THE COUNCIL FOR JUSTICE AND PEACE**

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### **Congregation of the Brothers of Charity**

The Brothers of Charity Services Ireland is made up of six service companies and one national company. Each company provides services in its own geographical area (Clare, Galway, Limerick, Roscommon, South East, Southern). These services aim to support and empower people with an intellectual disability/autism.

### **Congregation of the Sisters of Mercy**

There are four publicly funded hospitals in the Dublin area that are ‘under the care of the Sisters of Mercy’. These are: the Mater Misericordiae University Hospital, Children’s University Hospital, Cappagh National Orthopaedic Hospital and the National Rehabilitation Hospital. The latter is in the process of being transferred to an independent trust, with its status as a voluntary hospital being maintained.

### **Daughters of Charity**

The Daughters of Charity have provided services to people with an intellectual disability in Ireland for over a century. Today these services are based in Dublin, Limerick and Tipperary and include community based residential services; crisis intervention and respite care; day activation for children and young adults; child development services, education services, work activation and vocational training; sheltered, supported and open employment; and services for older people with intellectual disability.

### **Little Company of Mary**

The Little Company of Mary is an international religious congregation founded in Nottingham in 1877 by Venerable Mary Potter. Its mission is

to bring the healing love of Jesus to the sick and suffering and especially those who are dying – physically, spiritually and psychologically. In Ireland, the sisters work in the care of Older People, pastoral care, parish ministry, prison ministry and university chaplaincy. Milford Care Centre, Limerick, is under the auspices of the Little Company of Mary. It is a company limited by guarantee. This is an example of public–private partnership (including volunteers) caring for the needs of the elderly and providing palliative care, day care services and health education for the people of the Mid-West region. Sisters serve on the Board of Directors and Management Committee of Milford Care Centre and St John’s Hospital, Limerick.

### **Little Sisters of the Poor**

The congregation was founded in 1839 and its principal mission was to care for the elderly. It continues this mission today, with three homes in Ireland, two in Dublin and one in Waterford.

### **Medical Missionaries of Mary**

The congregation is no longer involved in the provision of health services in Ireland. Its focus has always been on health care and medical services in developing countries, particularly East, Central and West Africa and Brazil and Central America. This remains the case today.

### **Religious Sisters of Charity**

The congregation was established in 1815 and went on to found St Vincent’s hospital, the first Catholic hospital in Ireland, in 1834. The Vincent’s Healthcare Group, Dublin, currently comprises St Vincent’s University Hospital Ltd, St Vincent’s Private Hospital Ltd and St Michael’s Hospital, Dublin. There are two hospice facilities in Dublin, Our Lady’s Hospice and Blackrock Hospice, in addition to a range of other centres: Caritas Convalescent Centre Ltd, St Monica’s Nursing Home Ltd, St Mary’s Centre (Telford) Ltd, St Oliver’s/Loyola, St Margaret’s Centre. In Cork there is a hospital, St Patricks, Marymount Hospice and St Margaret’s Centre. In Kilkenny there is St Patrick’s Centre.

### **Sisters of Bon Secours**

This international religious congregation was founded in Paris in 1824, with a mission to care for the sick, the dying and the poor. Bons Secours Health System, under the sponsorship of Bons Secours Ireland, currently operates four acute care hospitals based in Cork, Dublin, Tralee and Galway and one long-term care facility at Mount Desert, Cork, comprising a total of 850 beds.

### **Sisters of St John of God**

The congregation no longer owns any health care facility. A small number of sisters are employed as nurses in HSE facilities. Others are involved in the care of the elderly, in parish-based sheltered accommodation settings at Owing, Co. Kilkenny, Rathdowney, Co. Laois, and Enniscorthy, Co. Wexford.

### **St John of God Services**

St John of God Hospitaller Services supports up to 3,000 children and adults with a range of needs, including intellectual disability, mental health difficulties and problems associated with ageing. The congregation has an independent acute psychiatric teaching hospital with 183 in-patient beds, St John of God Hospital, Dublin, and offers a wide range of other services at centres throughout the country.