

*Address by Ombudsman,*

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*at IMO Doolin Memorial Lecture 2011*

*on Health Care in Ireland*

*"An Ombudsman Perspective"*

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## INTRODUCTION

I'm delighted, and very honoured, to have been invited to deliver this year's Doolin Memorial Lecture. I am the 47th speaker at this annual event. From what I've read about William Doolin, I'm sure that what he would want is that our health services in Ireland should be subject to critical but constructive comment at this lecture held in his honour.

My credentials for speaking on health care in Ireland are based, not on being a health professional or a health policy analyst or a health economist but, rather, on the fact that in my role as Ombudsman I deal on a daily basis with complaints from people who are unhappy with their experience of the health services. Of course, like everyone else in this society I have my own experience of how the health service works (or sometimes does not work) for myself and my family.

Meeting the health needs of a modern, developed society like ours is an extraordinarily difficult and complex business. And despite the enormous turmoil in our financial and banking world, we are still a modern, developed and relatively wealthy society. Nevertheless, it is impossible to ignore the enormous uncertainty facing us at present - both in terms of our own immediate budgetary situation and in terms of what might happen in the Eurozone more generally over the next few months. What is absolutely certain is that funding for our health services is being, and will continue to be, cut in the short term. These cuts are inevitably having a negative impact on services. For example, some public nursing homes have been closed down because the funding is not there either to meet staffing costs or to provide the capital costs of bringing the homes up to standard. It is being suggested that many more public nursing homes will be closed before very long.

And of course not all health service cuts will be immediately obvious or even announced. A scheme of particular interest to me at present is the Motorised Transport Grant, paid by the HSE to certain people with disabilities. Not many people would be aware of this scheme but for those receiving the grant it is important. It appears there has been a significant (if unannounced) curtailment of the scheme in some parts of the country. I'm currently looking at a few complaints about this scheme from Co. Donegal where there has been, by all accounts, a very significant cutting back on the grant. Figures provided by the HSE in a PQ reply to Deputy Caoimhghín Ó Caoláin show that in Co. Donegal the approval rate for grant applications dropped from 75% in 2007 to 25% so far in 2011. This dramatic curtailment arises from what the HSE in Donegal refers to as "*the current strict interpretation of the guidelines*" arising from the reduced health budget.

It seems to me that how we manage this situation of reduced levels of service is critical. There needs to be absolute transparency about where cuts are being made and about their consequences. We, as citizens and taxpayers, are entitled to know what exactly is happening with our own health service. Unfortunately, it seems to be a core characteristic of our political culture that where there is bad news in the offing there will be concealment or, at least, equivocation. To take what may seem to some to be the relatively minor example of the Motorised Transport Grant, the fact that the grant is being curtailed for budgetary reasons is something which the HSE should have announced - and not something coming into the public domain indirectly because a

politician asked a Parliamentary Question. And of course the same comment might be made in the case of many other services which have been curtailed: ranging from dental care for medical card holders to the home help service for older people and the payment of subsidies under the Nursing Home Support Scheme. It emerged recently, indirectly as far as I can establish, that payments under the Nursing Home Support Scheme are being commenced from the date of the decision to award a payment rather than from the date of application or the date of entry into the nursing home. This, presumably, is a money saving exercise also.

It may be one of the consequences of the abolition of the health board structure that accountability mechanisms within the public health service appear to be less, rather than more, effective.

However, my main focus today is on the medium to longer term development of our health services and what we should hope for when we come out of this present crisis. Because of the complexities involved, it seems to me we need to stand back and take an overview which focuses on the basics of what we want and of how "what we want" should be financed and delivered. I have no illusions that in 35 minutes or so I can map out a blueprint for the healthcare system of the future. What I hope to do, rather, is to identify two issues or themes which, in my view, deserve serious consideration in developing our healthcare system. I am very conscious that the present Government is committed to a quite radical overhaul of our health services; the Government's proposals are intended to be introduced over a period of several years and much of the detail of its proposals remains to be revealed. My comments today are made by way of a contribution to the debate on how the Government's proposals should be further developed.

The first issue I want to raise today is the fact that we have a bad record in Ireland in actually achieving what we set out to achieve in the health area. One of our biggest difficulties to date has been the failure to implement health policy; policy, after all, is only as good as its implementation. Sustained failure to implement policy, especially where policy has been given the strength of law, is bad for those individuals who do not get their entitlements; but it is also bad for us as a society.

The second issue has to do with what model of healthcare we propose to follow in the future. The model of healthcare which we opt for reflects the kind of society we want to be; it also shapes how we relate to one another. President Higgins has recently thrown down the challenge of whether or not we want to be a "real republic". How we organise our healthcare will go some way towards answering that question. We need to ask whether it is a mistake to retreat from the model of providing health services by and through the public sector. Maybe we should not give up on the public sector just yet!

### **IMPLEMENTING POLICY**

Some of you will recall that just about a year ago I published a report called *WHO CARES? An Investigation into the Right to Nursing Home Care in Ireland*. The report was based on more than 1,000 complaints received by myself and my predecessors in the period since 1985. These complaints were made by, or more usually on behalf of, older people who needed long-term nursing home care and who had failed to have that care provided for them by their health board (more recently, the HSE). Because the health boards had failed to provide this care, the older

people in question had to avail of care in private nursing homes at considerable cost to themselves and/or their families.

Health policy regarding the provision of long-stay care for older people was given legal expression within the Health Act 1970. The Health Act 1970, as I understand it, created a legal entitlement to be provided with "in-patient services" which, in the case of older people, included nursing home care. I'm not going to deal here in any detail with the complexities of the legal issues raised in this report. My overall conclusion was that the State, through its agencies the health boards (HSE) and the Department, had failed over many years to provide people with their legal entitlement to nursing home care. This failure, I concluded, had inevitably caused confusion, suffering and hardship. The Government and the Minister for Health at the time rejected my conclusions. Indeed, while I was preparing that report the then Minister for Health, Ms. Harney, took the unprecedented step of writing to me, on behalf of the Government, to say that the then Government agreed with the Minister's rejection of a draft of my report.

In any case, what is relevant to what I have to say today is this: our national health policy in relation to nursing home care for older people was provided for in the Health Act of 1970, more than 40 years ago. Between 1970 and 2009 that policy in very many cases (I'm not saying all cases) was not implemented. And I am not in any way convinced that this long-running failure had anything to do with uncertainty in the law or with any confusion as to what the State's commitment was. As evidenced by the complaints dealt with by my Office, this was a wilful and knowing disregard for policy and, more importantly for the law, on the part of the State's health authorities.

Many of you will be aware also of another major disregard for the law and for policy, over 30 years, in a related area. In 1976 a Supreme Court ruling established very clearly that, in those cases where they were providing nursing home care for older people, health boards were not entitled to impose any charge where the patient was a medical card holder. Despite the clarity which the Supreme Court had brought to the situation, the health boards (again, with the support of the Department of Health) found ingenious but illegal ways to impose charges. These charges continued in place until 2005 when the Department eventually accepted that they were illegal. The Health Repayment Scheme was set up in 2006 to repay these illegal charges and to date roughly €450 million has been refunded.

The examples I've just mentioned might be seen as simply isolated and specific instances of failure to implement policy. Maybe so. But if we look at the expression of health policy at the macro level we find all too often that rhetoric very much trumps action. We've had quite a few detailed policy or strategy statements from Ministers for Health in the past two or three decades, all of which have been well regarded. The problem is that in many respects these policy statements have not been acted upon. [I spoke about this at a talk in the Mater Hospital in September so some of what follows may be familiar to some of you!]

The 1994 strategy document, *Shaping a Healthier Future*, set out three principles as underpinning the entire Strategy: equity, quality of service and accountability. As the then Minister commented in his introduction:

*"Health policy, I believe, unerringly reveals the values that drive a society and the commitment of Governments to social justice."*

The 2001 strategy document, ***Quality and Fairness***, reflected a similar commitment to fairness and social justice. The vision espoused in this document is one of:

*"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."*

I think there is a general acceptance that our health services in practice have not lived up to the ideals expressed in ***Shaping a Healthier Future*** and in ***Quality and Fairness***. As Dr. Fergus O'Ferrall put it in 2007: *"There continues to be a deep and general malaise in respect of the structures and performances of our healthcare services."* I wonder whether this malaise is inevitable in circumstances where the theory and the promise, on the one hand, are so out of line with the actual reality, on the other hand.

An area of performance attracting critical comment has been the relative failure to develop Primary Care Teams (PCTs). In 2001 the Department of Health published a policy document entitled ***Primary Care: A New Direction***; this envisaged a very significant development in the area of primary care which would *"become the central focus of the health system"*. The plan was for the creation of multi-disciplinary PCTs throughout the country with a target to have 400 - 600 such teams in place by 2011. The HSE's revised target was for 471 Teams in place by end September 2011. The most recent figure I've seen is that there are currently 393 PCTs in place. Unfortunately, it seems many of these Teams are not functioning as they should.

The Irish College of General Practitioners has very recently published the results of a GP survey which has reported that, of 195 respondent GPs involved in PCTs, 65% of them described their Team as functioning poorly. I discussed PCTs recently with a GP who is involved with a Team. He sees the great potential of PCTs, but he is enormously frustrated with what's happening in practice. While PCTs are intended to move care from the hospital into the community, there is no mechanism yet in place (he says) to allow the funding to follow the patient. Many of the Teams, according to my GP informant, are "virtual" Teams; the members do not work out of the one premises nor do they have good communications systems to compensate for the lack of co-location. Another bugbear for my informant is that there is poor continuity of care as the HSE staff involved (public health nurses and social workers in particular) are moved far too frequently. In fact, according to the HSE's most recent Performance Report, there are currently 450 PCT posts unfilled. All in all, progress with the PCT approach has been disappointing.

Clearly, the present Government is starting from the premise that the ideals of ***Shaping a Healthier Future*** and of ***Quality and Fairness*** have not been honoured. It is worth noting that the present Government's plans are stated to be grounded on the principle of "social solidarity"; furthermore, it talks of ending the present *"unfair, unequal and inefficient two-tier health system"*. This rhetoric is not unlike the rhetoric of ***Shaping a Healthier Future*** and of ***Quality and Fairness***. It seems that the same policy vision - embracing fairness, equity, high quality of service - is shared by the Irish Medical Organisation. Its recent Budget submission is very strong

on the urgent need to deal with inequalities in the health services. It is rather extraordinary that, while successive Governments and the largest medical representative body share the same policy objectives, the policy itself has not been implemented to any great extent.

There has been a particular failure, over several decades, to implement policy in the mental health area. Currently, State policy in the mental health area is set out in the 2006 report of an expert group entitled ***A Vision for Change***, whose recommendations have been accepted by Government. A ten year plan has been put in place to implement these recommendations. Writing in his Foreword to the 2010 Annual Report of the Mental Health Commission, the Chairman of the Commission commented: "*We are now at the half way point in the ten year timetable envisaged for the implementation of **A Vision for Change**, and we have not seen the fundamental changes envisaged when the document was written.*" He noted that the core proposal of the policy "*is the reorientation of the delivery of mental health services away from the old style model of institutional care to community based services*" and that progress on this is far too slow.

What we should remember here is that precisely the same proposal for a reorientation towards community services was made as far back as 1966, 40 years earlier, in the ***Report of the Commission of Inquiry on Mental Illness***; it noted;  
*"In recent decades, there has been a growing appreciation of the fact that institutional life can be disabling in its effects—emotionally, physically and socially—and that many patients can be treated, with increased prospects of success, in their normal social environment. The success of community care, however, depends on the development of a number of special facilities within the community."*

And the same approach was advocated 22 years earlier, in 1984, in the Department of Health's own policy document on mental health called ***Planning for the Future***.

Within the overall mental health area, there has been a particular failure to make proper provision for the needs of children and adolescents. This is something my colleague, Emily Logan, Ombudsman for Children, dealt with in her 2006 ***Report to the UN Committee on the Rights of the Child***. Emily Logan drew attention then to the fact that there are large gaps in the mental health services for children and adolescents; and she was especially concerned that young people are frequently being treated within adult services - including as in-patients.

The Mental Health Commission in its most recent annual report says that, while there has been some improvement, it continues "*to hold the view that the provision of age appropriate mental health services for children and adolescents must be addressed as a matter of urgency*"; and it refers specifically to the continuing practice of accommodating young people in adult in-patient services. All in all, the situation regarding mental health services for children and adolescents has to be seen as quite unsatisfactory.

Moving away for the moment from the healthcare area, there does seem to be some generalised weakness in our capacity to implement official policy in Ireland. About two weeks ago the Institute of Public Administration published a report in its ***State of the Public Service Series*** looking at the overall performance of Ireland's public administration. The IPA report says that, in

general, the quality of Ireland's public administration remains close to the average for the European Union. The report, however, identified some specific weaknesses in Irish public administration: one of these weaknesses relates to the implementation of policy. The report, using data from surveys of business executives, concludes that in Ireland, "*the implementation of government decisions is seen to be worsening relative to other European countries*".

I'm making these points about our failure to implement policy, not to have a cheap shot at the health authorities, but because for any new policy to succeed we need to be mindful of where we have failed in the past.

### **WHAT MODEL OF HEALTHCARE?**

Our present healthcare model in Ireland is something of a hybrid when compared to the textbook models described in the health policy literature. Our present arrangements include the following characteristics:

- we have a mixed public/private healthcare system;
- about 38% of people, those with medical cards, have free GP care and free prescribed drugs (subject to a small charge); most others must pay for GP care and some of their drugs' costs;
- about 48% of people are covered by private health insurance;
- there is a right to be provided with hospital in-patient and out-patient care for everyone subject to charges (though there are no charges for medical card holders);
- according to the Department of Health, there is no right to long-stay nursing home care for anyone but the State may subsidise such care within the limitations of the funding available;
- almost all GPs are private practitioners;
- consultants in public hospitals are mostly free to engage in private practice either within the public hospital or elsewhere (though there are restrictions in some cases) ;
- we have a "two tier" system under which those who can afford private care (or have insurance) are likely to be seen and treated more speedily than those who must rely on the public system.

A feature of our system is that private healthcare is subsidised very considerably by the public system - in terms of professional training, use of public facilities and substantial tax concessions for capital costs. Eighty percent (80%) of all health spending in Ireland comes from the public purse.

A peculiarity of our system of public health service is that it operates half in and half out of a legislative framework. Leaving aside the area of mental health, in terms of people's entitlement to health services and the corresponding obligation on the State to provide services, what we have is the Health Act 1970. This Act is more than 40 years old and, while it has been amended on many occasions, it is now a very inadequate expression in legal terms of what health policy seeks to achieve. For example, it is silent on the issue of Primary Care Teams - even though for

the past ten years they are meant to be the "central focus" of the health service. Since 1970, many services have developed which are now seen as essential elements in the overall healthcare system but which are not provided for in the Health Act 1970. These services include home care packages, day care services, physiotherapy, occupational therapy, speech and language therapy and several others. In particular, the provision of services for people with disabilities - to the extent that they do not fall neatly into the 1970 Act categories - remains very uncertain.

As Ombudsman, I am aware from complaints I deal with that there is a considerable level of dissatisfaction with our health services - both in terms of the services available and in terms of how services are delivered. There have in recent times been too many high-profile instances of negligence, carelessness and down-right scandal within the public health system - the blood products scandal, various issues in Drogheda, Ennis, Tullamore and Tallaght Hospitals as well as failures in regulation such as with Leas Cross Nursing Home. At the same time, it strikes me that people generally are very attached to the public health service, such as it is, and do not want to see it dismantled. I wonder, for example, whether the public agitation for the retention of specialist services, of local hospitals and public nursing homes - in Sligo, Roscommon, Monaghan, Navan, Abbeyleix and Athlone, for example - is more than simply a knee-jerk objection to any loss of a local facility. I wonder if it also indicates an attachment to the notion of an important public service being visibly present as an integral part of the local community.

It seems to me that there is a certain ambivalence at play in the public's attitude to direct State involvement in the provision of health services. On the one hand the HSE, like the health boards before it, is subject to a great deal of criticism; and undoubtedly there has been good cause for much of this criticism. On the other hand, the public wants to hold on to its hospitals and health centres and to the local public health nursing service and so on.

For quite some years now there has been something of an ideological battle being waged against the public sector generally and including against the public health sector. The principal charges against the public sector are that it is antiquated, stale, inflexible, tied to rigid work practices, bureaucratic and opposed to change. And of course it is extremely expensive. Critics of the public service either want it dismantled, with services provided instead by the private sector; or, if the public sector is to survive, critics say that public servants should learn to follow private sector standards. I think that it would be a serious mistake to allow the discussion, such as it is, to become polarised along ideological lines.

I and my two predecessor Ombudsmen have been quite critical of the health boards and of the HSE; every Ombudsman annual report since 1985 has outlined instances of health service failures and bad practice. One of the first health service complaints to be reported on by then Ombudsman, Michael Mills, was in his Annual Report for 1985. The complaint arose from the refusal of the Department of Health to sanction payment by the Mid-Western Health Board of the costs of hospital treatment abroad. Following intervention by Michael Mills, the Department accepted that the treatment in question was not available in Ireland at the time when the complainant went abroad for the treatment and the Health Board was authorised to pay the costs.

Twenty five years later, I reported on another such complaint. The complainant was a woman from another EU member state who had worked in Ireland for several years; she contracted

cancer and needed chemotherapy and radiotherapy. She was unmarried and had no family member or close friend in Ireland who would be available to support her while undergoing these treatments. The Irish hospital encouraged her to return to her own country for treatment as it meant she would have the support of her family there throughout the treatment. As she was last insurably employed in Ireland, her own country treated her as not covered by its health service and she incurred costs of almost €9,000. She claimed for these costs against the HSE but was refused on the grounds that the treatment was actually available in Ireland. While this was true, strictly speaking, it took no account of the fact that because of the severity of the treatment she would need to be supported, outside of hospital, for the duration of the treatment. Following protracted exchanges between my Office, the HSE, the Department and the hospital here, it was agreed that the woman should have the €9,000 costs refunded to her.

I'm mentioning these two complaints, firstly, to show that the same issues continue to recur and, secondly, to make it clear that I am not under any illusions about the performance of our public health service at present. I and my predecessors in Office have had to deal with many challenging complaints against the health boards/HSE and the Department; many of these complaints have been resolved to the satisfaction both of the complainants and of my Office. I would say that some of the generalised criticisms of the public sector I've mentioned are, or at any rate, have been valid in the case of the public health service. But that is not the full picture. It is only proper to ask whether the health boards and the HSE have had a fair chance to deliver an acceptable service. I am not convinced that they did have such a fair chance.

Based on the recommendations of McKinsey Consultants, the health boards were structured on the basis of three programmes - Community Care, Hospitals and Special Hospitals - each with its own Programme Manager. While time does not allow for a detailed account today, it seems to me that each of the three programmes had to operate under a serious disadvantage.

In the case of the Community Care Programme, the key innovation was the establishment of Community Care Teams which were intended to bring together in one team, and for a defined population, doctors, nurses, social workers, community welfare officers and (where they existed) community physiotherapists, speech and language therapists and so on. In a sense, these teams anticipated the Primary Care Teams of today - though the Community Care Teams served larger populations than do the Primary Care Teams. A very significant problem for the Community Care Teams was that the GPs, as is still the case, were private practitioners. While they worked under contract for the health boards to provide a service to medical card holders, they were not health board employees and they had no place on the Community Care Teams. Nevertheless, the directors of these Teams were all health board doctors; but coming from the public and community health disciplines and not from general practice. The insistence that the Teams be led by these doctors was a cause of tension and friction within the Teams; and these difficulties were not helped by the fact that, as it appears, some of the Directors lacked management skills and experience. So, a structure which might have worked well in the right circumstances was not given a fair chance to prove itself.

In the case of the Hospitals Programme, it suffered from the outset from the difficulty that it neither owned nor managed many of the larger hospitals where most of the specialised services

for public patients were located. In fact, almost 50% of the public hospital beds were in hospitals which the health boards neither owned nor managed.

In Dublin, for example, the Mater, St. Vincent's, St. James, Tallaght (Adelaide and Meath), Beaumont (Jervis Street, St. Lawrence's), Crumlin and Temple Street, Holles Street, the Coombe and the Rotunda - all of these were and remain non-health board hospitals. While they were almost totally state-funded, and were vital to the provision of public hospital services, they were effectively outside of the control of the then Eastern Health Board. This was true also, but to a lesser extent, in Cork, Limerick and Galway. These hospitals were funded directly by the Department of Health for most of the period of the existence of the health boards. The fact that the health boards did not own or manage these major hospitals, and that the funding arrangements by-passed the health boards, meant that their capacity to engage in meaningful planning and delivery of an integrated hospital service was significantly diminished.

In the case of the Special Hospitals Programme, dealing with psychiatric services and services for the elderly, it was always the Cinderella service in terms of funding and attention. Some of you will no doubt recall the annual reports of the Inspector of Mental Hospitals who, year in and year out, reported on buildings, facilities and regimes of "care" which undoubtedly involved breaches of the human rights of those condemned to avail of these services. The sheer awfulness of the public mental hospitals during the health board years was in stark contrast to the more salubrious facilities enjoyed in the small number of private psychiatric hospitals. These private hospitals, particularly for the first 15 years of the health boards (up to 1985), had the advantage of a considerable stream of income payable from the State's health insurance company; the Voluntary Health Insurance was particularly generous in covering the in-patient "treatment" of alcoholism in private hospitals. The health boards' own mental hospitals generally had no private patients - perhaps not surprisingly - and could not count on the VHI's generosity. With inadequate State funding, and with no private patient income, the health boards' capacity to provide a good and decent mental health service was compromised from the start. Furthermore, the fact that services for the articulate, better-off in society were provided in exclusively private facilities meant that those who might have been expected to agitate for improved standards did not need to do so.

Public nursing home care for the elderly suffered from much the same neglect during the health board years. The public nursing homes deprived of capital investment over the last 40 years are now the homes likely to be closed because they do not meet HIQA's standards.

I do not pretend that these comments about the health boards and the HSE constitute a proper analysis of why those bodies have, to a large extent, failed in their roles. I hope, though, that they show the need for a thorough analysis of why our public system has been unsatisfactory and that the tendency to write off the public sector health service, in favour of the private sector, is premature. Yet it does appear that in certain areas of health provision, the role for the public health sector is being eroded rapidly. This is most obvious in the area of nursing home care for the elderly. This is a development which began to emerge while the Celtic Tiger was still alive and apparently well; but it is not a development which can be grounded in any of the major health policy or strategy documents published in the past 20 years.

There are two sides to this development. The first is that, since 2001, the State has encouraged and facilitated a dramatic expansion in the private nursing home sector by way of very generous tax concessions. While this development has been hugely significant for the public health service and for health policy, the initiative emanated from the Minister for Finance rather than from the Minister for Health. The number of nursing home places in private, commercial nursing homes increased from 6,932 in 1997 to 20,590 in 2010 - an increase of almost 300 per cent. The second side to all of this is that the increase in private nursing home beds was accompanied by a significant drop in the number of public nursing home places. While it is difficult to ensure that one is comparing like with like, it appears that in August 2011 the HSE had just 6,100 long-stay beds for the elderly - a very significant drop on the figure of 10,067 long-stay beds held by the health boards in 2001. And we know from comments made recently by the Minister for Health that very many more HSE nursing homes are likely to be closed in the near future.

And on the subject of comparing public and private nursing homes, one issue which crops up regularly is the apparent disparity in costs as between public and private care. Recent figures I've seen say that the weekly cost per patient in a public nursing home is about €1,350 and up to €1,800 per week in some smaller units; the equivalent figure for patients in private nursing homes, availing of the Nursing Home Support Scheme, is €850 per week. What is not said, very often, is that these figures are not comparing like with like. The costs of public nursing home care, as I understand it, reflect the fact that these homes cater very often for patients with more acute needs and who have available to them a wider range of service than is typically provided for in a private nursing home. Inevitably, the costs of public care will be higher on this basis. Furthermore, the real costs of private nursing homes should include the substantial subsidies, in the form of taxes foregone by the State, arising from the tax incentives availed of by many of the private nursing homes over the past decade or so.

I have to confess to a certain uneasiness about any approach which treats the health service as just another service which can be farmed out to the most competitive bidder. There has in recent years been an understandable focus on the need to make the health service more efficient and more responsive to the needs of the people it serves. Nobody can object to measures to improve value for money; it's in all of our interests that the health service becomes efficient, flexible and responsive to the changing health needs of the population it serves.

What I am uneasy about is the extent to which in the public sector generally, but more particularly in the health area, the language of the "new public management" is becoming predominant. This involves applying market principles and the language of consumerism and of competition in the area of health services. Under this approach, a health service is just another commodity for which consumers will be advised to shop around until they find a "provider" with the best "fit" for their needs. The type of language associated with the promotion of this type of approach seems designed to conceal what may be lost while hyping up changes which, on hard analysis, often appear to be negative rather than positive.

I haven't actually heard it said yet, but it cannot be long until we hear of proposals which will put "financial power" into our hands as prospective patients so that our choice of hospital will be "meaningful"; inevitably, exercising this choice will "enhance our patient experience".

An article I read recently on changes to the UK's third level education arrangements commented on the way in which in recent times *"official discourse has become increasingly colonised by an economistic idiom, which is derived not strictly from economic theory proper, but rather from the language of management schools, business consultants and financial journalism."* The article goes on to lament the elevation of the status of business and commerce such that *"contributing to economic growth [has become] the overriding goal of a whole swathe of social, cultural and intellectual activities which had previously been understood and valued in other terms"*.

There is a danger in Ireland that with our health services we may head, unheedingly, too far down this road of choice, competition, consumerism and commodification. If our health service is to reflect social solidarity, the ending of inequalities, and all of those principles which work to hold us together as a society, then we need to look carefully at any developments which remove healthcare from the communal public arena and re-locate it in the private arena of the marketplace.

It seems to me that a state's public health service should amount to far more than arrangements to ensure services are provided. Though of course it is essential that services are provided - after the first five hours waiting on a trolley in A&E one rapidly loses interest in the philosophy underlying the public health service! The context in which services are provided, the institutions providing them, the financing of the services, the governance arrangements for those services, the extent to which one is entitled to services - these are all factors which both reflect and support the maintenance of the kind of society we want to be. Health services made available on the basis of the exercise of consumer choice within a purely commercial private market do nothing to promote social solidarity or good citizenship. On the other hand, services provided through state agencies which are dysfunctional are not the answer either.

There is the beginnings of a debate in this country about the promotion of active citizenship and about how the citizen should relate to the key institutions of state. Dr. Fergus O'Ferrall, Director of the Adelaide Hospital Society, is one of those leading this debate. He has written about how, ideally, there should be citizen participation in Ireland's healthcare system. We are not very good in Ireland at engaging in this kind of debate. Many people will say, to revert to the A&E trolley case, that what matters is getting the patient off the trolley and that philosophical musings about why the patient is on the trolley in the first place gets us nowhere. It seems to me that we need to do both; that is, get the patient off the trolley AND reflect on how we want our healthcare organised and what values we want reflected in our healthcare arrangements.

Earlier, I referred to a challenge thrown down by President Higgins as to whether or not we want to be a "real republic". In what was his last major speech after nine years in the Seanad and 25 years in the Dáil, Michael D. Higgins gave this assessment of the state of the nation:

*"I believe no real republic has been created in Ireland. The failure has been of three kinds. There has been a failure in making political power republican, a failure in making republican any kind of administrative power and a failure with regard to communicative power. Without being technical about each of these, I think those who wanted Ireland to be independent would have envisaged a country in which there would be far greater distribution of power, that it would not be confined solely to the exercise of parliamentary democracy."*

The then Deputy Higgins went on to observe:

*"I believe an enormously high price has been paid for a kind of anti-intellectualism and authoritarianism in Irish culture. Therefore, I believe we need to draw one conclusion. We need not suggest that that which has failed us should or can be repaired. ... We need to go back and recover the promise of a real republic that would be built on citizenship and that would reject as outrageous in a republic the kind of radical individualism epitomised in that ugly statement of Michael McDowell's that inequality is needed for the stability of society."*

As Ombudsman for the public service, I was immediately drawn to Deputy Higgins's reference to *"a failure in making republican any kind of administrative power"*. What does this mean for the health service? I suspect it might mean that health policy and the administration of healthcare should not be by diktat and that they require some genuine engagement with ordinary citizens. I recognise immediately that this is a messy and somewhat unpredictable type of enterprise and certainly not one we have much experience of handling.

## **CONCLUSION**

We are currently in the midst of an enormous crisis the scale and extent of which is not even yet clear to us. We are seeking to regain our national sovereignty but, even on the most benign of scenarios, it will be several more years before we achieve this. We have time now to consider what kind of society we want to be once we come through the crisis. Any collapse in social solidarity, such as it is, would lead to enormous divisiveness within our society. We need to cultivate and promote greater social solidarity. Those who are bearing the brunt of the present suffering need to be able to have real hope that, in the future, we will have a more prosperous and a more equitable society. The provision of healthcare by the State will be a central element in any new dispensation.

While the comparison may not be completely fair, we are to some extent in a war zone. It is worth recalling that in Britain planning for its National Health Service began while the Second World War was still underway; the legislative basis for the NHS was laid down in 1946, shortly after the War ended, and the NHS came into operation in 1948. Can we draw any inspiration from this example? It seems to me that we can and that we should.

There are many groups which have a vested interest in how the health services are developed; these include health professionals, health administrators, the private healthcare industry, the health insurance companies, the pharmaceutical companies and so on. Clearly, some of these interest groups have more clout than others. The medical profession, represented by the IMO which hosts today's Doolin Memorial Lecture, will have quite a deal of influence on how our healthcare system develops in the future. I wonder is it utterly naive to hope that all of these interest groups might set aside their sectional interests for the wider common good? If not now, when?

Thank you.