

WHO CARES?

An Investigation into the Right to Nursing Home Care in Ireland



Oifig an Ombudsman
Office of the Ombudsman

A Report to the Dáil and Seanad in accordance
with section 6(7) of the Ombudsman Act 1980

Office of the Ombudsman

November 2010

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Contents

Foreword

1. This Report is about...
2. Challenge to Jurisdiction...
3. Background...
4. What complainants say...
5. The law provides...
6. Broken promises...
7. Nursing Homes Support Scheme Act 2009 -
“... making sure what has been in doubt...”?
8. Litigation - “... legal uncertainty is tested and exploited...”?
9. Conclusions and Reflections...

FOREWORD

This investigation report is based on more than 1,000 individual complaints made, since 1985, on behalf of older people who were unable to get long-term nursing home care from their health boards (HSE). Because they did not have care provided by the health boards (HSE), these people had no choice but to avail of private nursing home care. While many got some State support for the costs of private care, this support was inadequate. Many of the complainants said that having to avail of private care, even with State support, created huge financial and other problems both for the older person and for the wider family.

My approach in this investigation has been to describe the difficulties facing the families concerned, to seek to establish the legal situation regarding the right to long-term care and to describe how the responsible State agencies (the Department of Health and Children and the HSE) have been dealing with the problem.

Ten years ago my predecessor, Kevin Murphy, laid a report before the Dáil and Seanad titled *Nursing Home Subventions*. That report attracted quite a deal of public attention as well as causing some interesting debate within the Oireachtas. Part of the response at the time was a commitment that, insofar as the legal entitlements of older people to nursing home care might be unclear, there would be legislative action to put these matters beyond doubt. When I began work on this present report, in August 2009, the situation had not changed. In fact in 2009 I was receiving complaints about access to nursing home care which were no different to those Kevin Murphy received in 2000 or that his predecessor, Michael Mills, received as far back as 1985. Some of these complaints were resolved, on their own individual circumstances, to the satisfaction of the complainants. However, most of them were incapable of resolution because of a fundamental difference of opinion between my Office, on the one hand, and the health boards (HSE) and the Department of Health and Children, on the other hand, regarding the correct interpretation of the relevant legislation.

However, this is not simply a “look back” report. The issue of the right to be provided by the State with nursing home care remains very relevant. While the landscape has changed somewhat with the coming into operation of the Nursing Home Support Scheme Act 2009 (the so-called “Fair Deal” scheme) fundamental questions remain about the role of the State and the rights of the public in this area. This report attempts to answer these questions. It looks also at what might now be done - mindful of the current financial and economic difficulties - to assist those people who have suffered hardship by virtue of being unable to get long-term nursing home care from their health board (HSE).

Some of these people have chosen to initiate legal proceedings against the State. As detailed in the report, there are more than 300 cases currently before the High Court in which people are seeking compensation for the costs incurred in having to avail of private nursing home care where (as claimed by the plaintiffs) they should have had care provided by the health board (HSE). At the same time, much concern is being expressed at the moment about the apparent retreat of the State from direct involvement in providing nursing home care for older people.

The conduct of my investigation was hindered by the refusal of the Department of Health and Children and of the HSE to provide much of the information and documentation which I required. Fortunately, there was sufficient information available from other sources to enable me to complete this investigation satisfactorily. The refusal of full co-operation by the Department of Health and Children and by the HSE is very significant and is dealt with in the report.

I am now laying this report before the Dáil and Seanad in accordance with section 6(7) of the Ombudsman Act 1980.

EMILY O'REILLY
OMBUDSMAN

November 2010

1. THIS REPORT IS ABOUT...

I. This report is about...

This report deals with the role of the public health service in the provision of nursing home care for the elderly. It arises from the fact that, for more than 30 years, the question of what the State's obligation is in providing nursing home care for the elderly has been fraught with confusion, uncertainty, inconsistency and, not least, controversy. When people at a vulnerable stage of their lives, who need expensive nursing home care, do not know what their legal entitlement is to that care, and where this situation continues without resolution for 30 or more years, this has to constitute a major failing of government. And it is not as if the problems in this area have not been identified and discussed over the years.

The Ombudsman drew attention regularly to these problems in Annual Reports to the Oireachtas; reports for the years 1988, 1989, 1991, 1992 and 1994 in particular dealt with this issue. It was dealt with also in the 2001 Ombudsman report *Nursing Home Subventions*, in the 2005 Travers Report ⁽¹⁾ and a related report for the Oireachtas Joint Committee for Health and Children in 2005 as well as a number of legal and other academic commentaries. Some will say that another report on this issue is unnecessary now that (as it is argued) whatever problems there were have been resolved. This would seem to be the position of the Department of Health and Children (the Department). In

"... investigation which looks at the actions of the Department of Health and Children, of the Health Service Executive, and of some of the non-HSE public hospitals in providing for patients who are found to require in-patient services on a long-term basis. ...an "own initiative" investigation by the Ombudsman ... prompted by a persistent stream of complaints to the Ombudsman in recent years in which it is alleged that the HSE ... and/or a public hospital acting on behalf of the HSE, failed to provide in-patient services to a person in need of such services on a long-term basis."

Ombudsman Notification of Investigation (30 July 2009)

its initial reaction to the notification of this Ombudsman investigation, the Department commented that it was difficult to understand how the Ombudsman could take the view "that circumstances exist that would warrant an 'own initiative' investigation at this time." The Department and the Minister acknowledge that there have been major problems in our arrangements for nursing home care for the elderly but they appear to take the view that these problems have now been resolved with the commencement of the Nursing Homes Support Scheme Act 2009.

Whether or not these problems have been resolved is dealt with later in this report. It is worth bearing in mind that a previous attempt at remedying these problems was, on the admission of the current Minister for Health and Children, quite unsuccessful. In 1993, with the commencement of the Health (Nursing Homes) Act 1990, a scheme of nursing home subventions was introduced for residents of private nursing homes. In fact that scheme, which is now being replaced by the Nursing Homes Support Scheme (NHSS), proved very contentious and has given rise to a high number of complaints. Indeed, those complaints have continued right up to the present. Within the past year the Ombudsman

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

has settled a number of nursing home subvention complaints on an informal basis. In addition, during that period she completed three separate investigations arising from individual complaints including one composite investigation of ten separate complaints.

⁽²⁾ In each case, she found in favour of the complainant.

The Ombudsman takes no position on what, ideally, should be the level of State provision in any given health service area. Her concern is that the law should be clear and that State agencies should implement the law as it is rather than as they would wish it to be. Where resources to meet statutory duties are not available, the approach should be to recognise the difficulty and to seek to have the law amended to reflect practice. In the absence of amending legislation, and where services must be cut, maintaining mandatory services must take precedence over services which are discretionary.

“It is not acceptable that the availability of a [higher rate] subvention depends on where one lives rather than on one’s assessed need for a higher level of nursing home subvention. It is reasonable to expect that the HSE would arrange its affairs in a manner that the provision in particular of cash payments (whatever about other services) would be standardised across the country. One cannot, for example, imagine that the Department of Social and Family Affairs would pay an old age pension to people from Donegal but refuse such a pension to people from Mayo; or that the Revenue Commissioners would allow medical expenses income tax relief to people from Dublin but refuse such relief to people from Cork. One of the motivations for the creation of the HSE in January 2005 was to establish consistency of service provision across the entire country.”

Ombudsman Investigation (September 2010)

The question of whether the State should be involved in the provision, or in supporting the provision, of nursing home care is not in itself particularly complex; though it would seem to be difficult politically. The policy options are relatively simple:

- there will be no State support and it is a matter for each individual to provide for himself or herself; or,
- while the individual remains responsible for his or her own care needs, the State will provide some financial support in specified circumstances; or
- the State will take upon itself the responsibility to provide nursing home care for the elderly (just as it provides education for children or hospital treatment for people generally).

It is true that within these options there is scope for more specific arrangements (means tests, age limits, levels of dependency, tax relief, imposition of charges) but the basic options themselves are straightforward. It is also true that choosing one option over another has political ramifications. Whatever the level of State involvement, it is vital that the extent of it is very clear. It is of primary importance that people should know precisely what level of involvement the State proposes to have and how that involvement is to be delivered. In the normal course, one would expect these arrangements to be set out in legislation which is clear and unambiguous.

For 25 years complaints to the Ombudsman have been coming in, year after year, from families encountering major problems in getting nursing home care for an elderly parent or relative no longer able to live at home. It is true that there are some areas of public administration which give rise, year in and year out, to complaint: entitlement to social welfare payments or to housing and farm grants are cases in point. But with these latter complaints

the prevailing rules and regulations are relatively clear; and the issue for the Ombudsman is whether those rules and regulations have been applied fairly and correctly to the circumstances of the particular case. Complaints about nursing home care are quite different. In these cases there has been:

- continuing dispute as to what the law provides;
- a long history of failure to meet legal entitlements;
- the imposition of illegal charges;
- assessment of the means of family members where such assessment was illegal;
- major inconsistency across the country in the extent to which the right to public nursing home care has been met.

Above all, complainants have been telling the Ombudsman over these 25 years of their sense of impotence, frustration and distress and of the financial pressure they have endured arising from the manner in which they have been dealt with by the health boards, and more recently by the Health Service Executive (HSE). Nursing home complaints, clearly, are in a different league to Ombudsman complaints generally.

Looking back at the steady stream of nursing home complaints made to the Ombudsman over a quarter century, it is clear that at the very least the complainants want honesty and full information on what the law provides by way of services from the State. Unfortunately, what they have got is a fudge which fails to answer basic questions about entitlement and focuses instead on ad hoc solutions. Implicit in these complaints to the Ombudsman is a question mark over those governmental arrangements which have allowed such unacceptable practices to remain in place, virtually unchecked, for so long.

“The legislation on public nursing home care theoretically provides that everyone is eligible for such care...That theoretical entitlement of course is not realised in practice. We do not know how many people apply for a public nursing home place. The former health boards did not have a uniform application process (and the HSE has not introduced one) and some had no formal application process at all. Many people do not bother to apply because they know that they will not get a place”

Ita Mangan in Care of Older People, (SIPTU), (May 2006)

In recent years the term “systemic investigation” has been in use to describe a situation in which an Ombudsman takes a number of related complaints and conducts an investigation with a view to establishing (a) if these complaints are justified and (b) where the complaints are justified, the underlying systemic causes for the impugned actions. The Ombudsman’s Office has undertaken a number of such investigations over the years. ⁽⁹⁾ The term “systemic” may convey the notion that what is involved is a look at the machinery of public administration but in some instances it may also entail a more fundamental look at issues of governance. This present report arises from just such an instance. A deep-seated problem in an area of profound significance for the public generally, and which persists unresolved for more than 30 years, suggests that it is not just the machinery of public administration which requires to be considered.

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Rather surprisingly, the Department takes the view that the Ombudsman should not (as she does in this report) seek to represent the views of complainants; it has commented:

“The [Ombudsman] Act does not confer any jurisdiction on the Ombudsman to articulate questions about government on behalf of complainants. In considering that it does and in purporting to conduct an investigation and prepare a report on that basis, it is obvious that the Ombudsman fundamentally misunderstood the extent of her statutory role.”⁽⁴⁾

However, this view is at odds with the understanding of the role of the Ombudsman as expressed by the then Minister for the Public Service in 1985:

“Above all else the Ombudsman was appointed to speak and act on behalf of individual citizens. On their behalf he examines the actions of public officials and seeks a satisfactory remedy in those instances where he finds that a citizen has a genuine grievance. [...] I am glad to note, and Members of the House I am sure will feel likewise, that the Ombudsman’s perception of his role is concerned not only with the legal aspects of complaints, but also with the question of equity and fair play.”⁽⁵⁾

“By his availability to the citizen, coupled with his direct reporting relationship to the Oireachtas, the Ombudsman will provide a direct link between the people and the Legislature. Not only will he provide a means for the remedy of grievances about administrative actions but he will also help us as legislators to become more aware of the effects of the legislation which we enact.”

John Boland, Minister for the Public Service, Dáil Éireann, (8 July 1983)

This present report reflects the understanding of the Ombudsman’s role as articulated in 1985. It sets out the complaints made by more than 1,000 complainants and attempts to articulate on their behalf some fundamental questions about government which lie behind the individual complaints.

In the context of this report, therefore, the Ombudsman considers:

- why problems regarding public provision of nursing home care have come about; and,
- perhaps more importantly, why these problems have remained unresolved for so long; and
- why we have failed, over several decades, to achieve clarity as to what the State is intended to provide in terms of nursing home care.

Related issues to be considered include:

- why it is that the HSE (and previously the health boards) and the Department have failed consistently to acknowledge the HSE’s legal obligations in this area; and
- if it is the case, as seems likely, that the State bodies concerned believe we cannot afford to provide the level of provision which the law seems to require, why have we not amended the law to ensure State provision matches the resources available?

Ideally, this investigation should have been undertaken at an earlier point. However, two considerations persuaded the Ombudsman against an earlier investigation. The first is that, following publication of the 2001 Ombudsman Report ***Nursing Home Subventions*** the Department indicated (in November 2001) its intention to promote new legislation in the Oireachtas which would clarify entitlement to nursing home care and put services on a clear and unambiguous footing. The Ombudsman took the Department at its word but, unfortunately, relevant legislation did not

materialise until 2009 and it remains an open question as to whether it actually provides the clarity one would expect.

The second consideration influencing the Ombudsman's decision was her expectation that the key legal point at issue - whether people have an enforceable legal right to be provided by the HSE with nursing home care - would be decided by the Courts and that it seemed sensible to await that adjudication. In recent years several hundred individual legal actions have been initiated against the health boards/HSE, the Department and the State arising from the failure of the State to provide nursing home care for those in need of such care. The Ombudsman understands that the plaintiffs in these actions are seeking to be compensated for the costs incurred in having to avail of private nursing home care. The Ombudsman anticipated that, arising from this litigation, a definitive judgment would emerge on the key legal issue. In fact, at the time of writing, no such case has gone to hearing in the High Court and the legal issue has not been the subject of an adjudication. The question now arises as to whether the State agencies concerned have intentionally brought about a situation in which none of these cases has had an adjudication. The Ombudsman understands that some of these cases have been settled out of court and that these settlements involved some level of compensation, funded by the Exchequer, for the particular plaintiffs. In the circumstances, it is now reasonable to question whether, in fact, any of the cases will go to hearing and judgment. Against this background, the Ombudsman believes that the decision to postpone an investigation, and to await a ruling from the Courts, is no longer valid.

“Individuals are eligible for public nursing home care regardless of income. Access appears to be based on high nursing care needs, luck, ability to apply pressure, reluctance to entertain other alternatives (usually motivated by fear of high costs in private nursing homes) or a combination of all three”

Virpi Timonen in *Older People in Modern Ireland – Essays on Law and Policy*, Eoin O'Dell (ed.) (2006)

CONDUCTING THE INVESTIGATION

On 30 July 2009 the Ombudsman notified the Chief Executive of the HSE and the Secretary General of the Department of her decision to undertake an “own initiative” investigation into matters relating to the right to be provided with nursing home care by the State. The notifications to the two agencies were similar while not identical. The notifications made clear that the investigation, while prompted by individual complaints over many years, was concerned with the overall performance of the HSE (including the health boards up to 2005) and of the Department in dealing with the question of entitlement to nursing home care. The notifications said that the investigation would focus in particular on developments since 2001 when the previous Ombudsman had reported to the Oireachtas, in considerable detail, on similar issues. In particular, the agencies were told that the investigation would be looking at:

- the extent of the entitlement provided for at section 52 of the Health Act 1970; ⁽⁶⁾
- the extent to which the HSE (including public hospitals acting on its behalf) has been meeting this entitlement;
- various practices of the HSE (including those of public hospitals acting on its behalf) in situations where patients have not been provided with in-patient services

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

- and have, in consequence, had to avail of private nursing home care;
- the actions of the Department in seeking to resolve any lack of clarity regarding the intention of the legislature in enacting section 52 of the Health Act 1970;
 - the actions of the Department and/or of the HSE in response to legal proceedings initiated by or on behalf of patients seeking to vindicate their entitlements under section 52 of the Health Act 1970. ⁽⁷⁾

The Ombudsman told the HSE and the Department that she would require access to a wide range of records held by those bodies. In the case of the HSE, on 6 August 2009 the Ombudsman informed it that “in the context of the wider investigation the Ombudsman’s Office proposes to investigate the facts of a number of specific complaints made to the Ombudsman”; ten such complaints were identified. ⁽⁸⁾ On 20 August 2009 and 31 August 2009, the Ombudsman’s Office wrote to the HSE and to the Department respectively seeking the provision of relevant information and documentation. The information and documentation sought was broadly the same for the two bodies and covered:

- information on the legal proceedings against the bodies to include the number of cases, the nature of the claims in the proceedings, the approach being adopted by the two bodies and details of any cases settled and of settlement terms;
- documentation held in relation to the legal proceedings to include internal file notes, communications with the other body (Department or HSE) and copies of settlement documents;
- in the case of material otherwise protected by legal professional privilege (for example, legal advice), the Ombudsman’s Office clarified that such material was being requested rather than required under statute.

“When you see a social admission coming in, your heart sinks. You think when are they going to go home, because when they’re well there’s nowhere for them to go”

Hospital Doctor quoted in National Council on Ageing and Older People (Report No. 85) (2005)

The response of the Department to the investigation notification, and to the seeking of information and documentation, was to challenge the Ombudsman’s jurisdiction to conduct the particular investigation and to refuse to provide any of the material being sought. This was the final outcome following an exchange of communications with the Department during the months of September and October 2009. While the Department rejects this conclusion, the Ombudsman is clear that the Department has refused to comply with a statutory obligation to co-operate with an Ombudsman investigation and that this amounts to obstruction and hindrance of an investigation contrary to section 7(3) of the Ombudsman Act 1980. ⁽⁹⁾

Chapter 2 of this report deals in some detail with the failure of the HSE and of the Department to co-operate with the investigation.

The Ombudsman had intended to seek further information and documentation from the two bodies and envisaged that, in the normal way, senior staff in both bodies would be interviewed. Once it emerged that co-operation was being withheld, it was clear that the investigation could not proceed along the lines originally envisaged. In this new and unprecedented situation, the Ombudsman felt it essential that the investigation should proceed even in the absence of the critical contribution expected of the HSE and of the Department. ⁽¹⁰⁾ This report is the outcome of that investigation.

RESPONSES TO DRAFT REPORT

In the normal way with Ombudsman investigation reports, both the HSE and the Department were offered an opportunity to make representations to the Ombudsman before completion of the report. This procedure is specifically required under section 6(6) of the Ombudsman Act 1980 ⁽¹¹⁾ as well as being a requirement more generally under fair procedure. The Department and the HSE were provided with those portions of the draft report which might be regarded as containing material critical, or adverse to the interests, of these bodies. In fact, the material provided constituted the bulk of the report. Some of the content of the draft report was not provided on the basis that it did not constitute material of the kind which attracted a right of reply under fair procedure.⁽¹²⁾ In the event both bodies, while contending that they required access to the draft report in its entirety, made substantial submissions.⁽¹³⁾ Subsequently, following further correspondence on the matter, and in order to remove the basis for any claim of unfair procedure, the Ombudsman provided the Department with a copy of those portions of the draft report not provided previously.

In finalising this report, the Ombudsman has had regard to the matters raised in their submissions by the two bodies. The positions and contentions of the two bodies on specific issues raised in the report are set out in the individual chapters, as appropriate.

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Notes

(1) The “Travers Report” - officially titled *Interim Report on the Report on Certain Issues of Management and Administration in the Department of Health and Children associated with the Practice of Charges for Persons in Long-Stay Care in Health Board Institutions and related matters* (March 2005) - was commissioned by the Minister for Health and Children in December 2004 to “examine and report on the management within the Department of Health & Children of the long-term practice of inpatient charges in health board institutions”. The report was commissioned against a background of controversy regarding when the Department became aware that the practice of charging medical card holders for in-patient services was illegal.

(2) See most recent reports at <http://www.ombudsman.gov.ie/en/Reports/InvestigationReports/>

(3) Published at <http://www.ombudsman.gov.ie/en/Reports/InvestigationReports/> - for example, October 2008 - Investigation into the operation by Local Authorities of Waiver Schemes for Refuse Collection Charges; October 2007 - Complaints against the General Register Office; August 2001 - Passengers with Disabilities and 1999 - Report on Lost Pension Arrears

(4) Department’s Submission, Para. 36

(5) Seanad Debates, 17 October 1985 - Motion on Annual Report of the Ombudsman, 1984.

(6) Section 52 of the Health Act 1970 is the provision under which health boards (and now the HSE) are required to make available “in-patient services” to eligible people; nursing home care is a recognised component of “in-patient services”.

(7) In subsequent correspondence (letter to Department of 25 September 2009), the Ombudsman clarified that the “actions” being investigated did not include “*the Department’s handling of the litigation concerning the right to be provided with in-patient services*”; rather, what was being investigated was “*the actions of the Department of Health and Children, of the Health Service Executive, and of some of the non-HSE public hospitals in providing for patients who are found to require in-patient services on a long-term basis*”. However, she also clarified that information on how the litigation was being conducted was relevant to the investigation and, thus, she was seeking to be provided with information and documentation regarding the conduct of the litigation.

(8) Summaries of these cases are published on the Ombudsman website <www.ombudsman.gov.ie> in conjunction with this report.

(9) Section 7(3) of the Ombudsman Act 1980 provides: “*A person shall not by act or omission obstruct or hinder the Ombudsman in the performance of his functions or do any other thing which would, if the Ombudsman were a court having power to commit for contempt of court, be contempt of such court.*”

(10) Ironically, in responding to a draft version of this report, the Department has been critical of the Ombudsman’s failure in the course of the investigation to undertake “*a genuine engagement with the body and its personnel who are the subject matter of the report ...*” (Department’s Submission, Para.42)

(11) Section 6(6) of the Ombudsman Act 1980 provides that the Ombudsman “*shall not make a finding or criticism adverse to a person in a statement, recommendation or report under subsection (1), (3) or (5) of this section without having afforded to the person an opportunity to consider the finding or criticism and to make representations in relation to it to him.*”

(12) This was explained to the Department (letter of 6 August 2010):

“For your information, the content of the draft report which has not been provided to the Department consists, for the most part, of

- *suggested legal analysis of relevant health service legislation,*
- *a historical summary of complaints relating to long-stay care received by the Ombudsman (much of which has featured in earlier reports from the Ombudsman), and*
- *some commentary on governance issues generally.*

While this material may be of interest to the Department in a general sense, none of it constitutes material which might be regarded as affecting adversely the interests of the Department.”

(13) The full texts of these submissions are being published, in conjunction with this report, on the Ombudsman website <www.ombudsman.gov.ie>

2. CHALLENGE TO JURISDICTION...

2. Challenge to Jurisdiction...

Both the Department and the HSE have challenged the jurisdiction of the Ombudsman in conducting this investigation and both bodies have refused to provide information and documentation required by the Ombudsman for the purposes of the investigation. In the case of the Department, the refusal to co-operate extends to virtually all of the material sought. In the case of the HSE, while it provided material in relation to individual complaints, it refused to provide much of the other material required. In their submissions to the Ombudsman, having considered material from a draft of this report, both the Department and the HSE made further, and (in the case of the former) very detailed challenges to the Ombudsman's jurisdiction to undertake this investigation and to report on it to the Dáil and Seanad. For the most part, and insofar as the issue of jurisdiction is concerned, these submissions re-state and, in some instances expand on, the jurisdictional issues raised earlier.

This jurisdictional challenge is the most serious mounted against the Ombudsman's Office since its establishment in 1984. The extent and nature of this challenge, occurring both at the

“(The Ombudsman) also reports that there were legal challenges to his authority which seemed to be more concerned with preventing an investigation into particular complaints than the question of whether the complaints were justified. ...

The efficient discharge of the Ombudsman's role depends, to a large extent, on the co-operation he receives from the bureaucracy. Bearing this in mind, my Department issued guidelines to all Departments ... These guidelines did not leave any civil servant, irrespective of at what level he was serving, in doubt that they were expected to co-operate fully with the Ombudsman and his staff.

I am very concerned and disappointed, therefore, that the Ombudsman should have been hindered in any form while attempting to carry out the functions of his office. I need hardly say that I regard this absence of co-operation as tantamount to frustrating the intentions of the Government and of this House. Any lack of co-operation with the Ombudsman, irrespective from what quarter it emanates, will not be tolerated.”

John Boland T.D., Minister for the Public Service, Seanad Éireann, (17 October 1985)

outset of the investigation and at the stage of representations on the draft report, does raise serious issues for the Ombudsman as she goes about discharging her independent role. These issues were brought into even sharper focus when, on 10 September 2010, the Minister wrote ⁽¹⁾ to the Ombudsman, on behalf of the Government, to say:

- that she had drawn the attention of the Government to “certain aspects” of the draft report;
- that the Government supports the submissions made by the Department;
- that the Government “notes that you have not invited any comments from it on any of the contents of [the] draft Report notwithstanding that the extracts furnished

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

- to the Department raise issues of special concern to the Government ...”;
- that the report reflected “an approach to health funding and the provision of health services, which, if implemented, would ignore the very serious financial constraints on the Department, the HSE and the State generally and which would create

from influence by special interest groups, and it would support the freedom to assemble facts and reach independent and impartial conclusions.”

This recommendation, which has yet to be implemented, would put the Ombudsman on a par with other constitutional offices such as the Comptroller and Auditor General and the Attorney General.

“The Constitution confirms various personal and other rights which are protected by the courts. Without prejudice to this basic and general protection, additional protection is available in defined areas through recourse to the Ombudsman and this can be of particular advantage to those who are poor and without social position. An effective democracy requires that public servants should be held accountable for their actions and that citizens be protected from maladministration by public officials.”

Report of the Constitution Review Group, 1996

enormous liabilities that this State could not possibly afford and which the Oireachtas has never approved.”

The Ombudsman Act 1980 provides that the Ombudsman “shall be independent in the performance of his functions”.

This independence is an imperative. The Constitution Review Group recognised this in its 1996 Report when it recommended that the Office of Ombudsman be given constitutional status:

“Independence is the foundation stone upon which the office of the Ombudsman is based. The Ombudsman must be able to operate without being influenced by Government action. It is not enough for him or her to be independent in fact - he or she must also be seen as such by those who use the office. A constitutional guarantee for this independence would reinforce freedom from conflict of interest, from deference to the executive,

The Ombudsman is satisfied that neither the challenges by the Department, nor the Minister’s letter of 10 September 2010, have compromised her independence in this particular case. However, she would point out that no other Minister has ever written to the Ombudsman in such terms. In any event, and in order to avoid any risk of misrepresentation, the correspondence on these issues between the Ombudsman’s Office and the Department/Minister is being published separately on the Ombudsman’s website.

SUMMARY OF EXCHANGES WITH DEPARTMENT

On **30 July 2009** the Ombudsman notified an “own initiative” ⁽²⁾ investigation to the Department. The investigation concerned the provision of in-patient services under section 52 of the Health Act 1970 for patients requiring such services on a long-term basis. Details of the terms of the investigation, as notified to the Department, are set out in Chapter 1.

On **21 August 2009**, the Department replied making clear that it had serious reservations about the investigation. It said it would “assist the Ombudsman in the carrying out of any investigation that operates within the parameters of the Ombudsman Act 1980 ...”. It referred to the litigation to which it and the HSE are parties and expressed concern that “the proposed investigation ... will not undermine

or impinge upon the State's defence of this litigation"; further, it said there "is a real risk that an investigation ... will have a negative impact on the State's conduct of the defence of the litigation". The Department argued, as the "actions being investigated are the subject matter of court proceedings", that the Ombudsman could not investigate without showing that "special circumstances" exist which warrant an investigation.

The Ombudsman's reply of **25 August 2009** explained that the jurisdictional restriction referred to by the Department does not arise in this case. The restriction "precludes investigation by the Ombudsman of an action in relation to which the person affected by the action has initiated civil legal proceedings in any court"; since this is an "own initiative" investigation, there is no specific complainant so the restriction does not arise. The Ombudsman's letter continued:

"You express some concern that the Ombudsman's investigation may 'undermine or impinge upon the State's defence of ... litigation' arising from the non-provision of in-patient services. A related matter is the Department's position that 'the interpretation of statutory provisions ... [is] a matter for the Courts rather than one on which the Ombudsman should express a view'. The implication would seem to be that the Ombudsman's investigation might cause certain facts to be brought into the public domain, or draw attention to a particular legal analysis, which might prove helpful to the litigants in question. The suggestion is that the Ombudsman should not proceed with the investigation at this point because of the potential to undermine the State's defence of the litigation. This suggestion is at odds very fundamentally with the statutory role of the Ombudsman which is, acting independently, to investigate the actions of public bodies whether on foot of specific complaints or

"Whatever the reasons for it, I want to be emphatic about one thing: it is not now - nor has it ever been - acceptable that institutions behave or are treated as being above the law of the State. This is a Republic - the people are sovereign - and no institution, no agency, no church can be immune from that fact."

Dermot Ahern, Minister for Justice, Equality and Law Reform (26 November 2009)

acting on her own initiative. The implication in the Department's suggestion is that the Ombudsman, in fulfilling her statutory role, should act in a manner which protects the interests of the HSE and the Department to the detriment of the interests of complainants and of the public more generally. Clearly, the Ombudsman cannot accept that this is a correct view of how she should perform her statutory role. As for the Department's position that the Ombudsman should not express any view on the interpretation of statutory provisions, the Ombudsman does not agree: virtually all complaints dealt with by the Ombudsman involve taking a view on how legislation should be interpreted."

On **31 August 2009** the Ombudsman wrote to the Department specifying a range of information and documentation which the Department was required - under section 7 of the Ombudsman Act 1980 ⁽⁹⁾ - to provide for the purposes of the investigation. Details of what was sought have already been given in Chapter 1.

In its reply of **11 September 2009**, the Department raised issues regarding the time period covered by the investigation and whether the Ombudsman had jurisdiction to investigate actions going back over a period of several years. More fundamentally, the Department argued that the Ombudsman does not have jurisdiction to conduct a "wide-ranging investigation" of the kind proposed and that,

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

in any event, the Ombudsman is confined to investigating “actions taken in the performance of administrative functions”. The Department took the view that “*the directions/requests for documentation/information ... go considerably beyond anything necessary to investigate the performance of any administrative function by the Department or the HSE*”. The Department made much of its entitlement, as is the case with any party to litigation, to defend its position and to withhold from the Ombudsman not just privileged material but also confidential material.

The Ombudsman made a detailed reply on **16 September 2009** which restated the requirement under section 7 of the Ombudsman Act 1980. In particular, the Ombudsman commented as follows in relation to the withholding of material claimed to be privileged or confidential:

“It is a matter for the Department to decide on whether or not to comply with the Ombudsman’s request: it can decide to do so or not to do so. However it is somewhat disingenuous to argue that, in making this decision, the Department is in the same position as is any ordinary party to litigation. The Department is a party to the litigation in its capacity, under the Constitution, as exercising the executive power of the State; the manner in which it exercises that function is a matter of public interest (not least to the extent that public money is involved in the conduct of the litigation). Choosing not to disclose this privileged material to the Ombudsman means that the Ombudsman will have only a limited understanding of how the Department acted in the conduct of the litigation. This, in turn, will have the consequence of the Ombudsman being restricted in how she performs her statutory functions. There may well be situations in which it might well be acceptable for a public body not to comply with a request from the Ombudsman for material covered by

legal privilege; equally, there are likely to be situations in which refusing such a request is not acceptable. It remains a matter for the Ombudsman to take a view on when a refusal is acceptable or unacceptable.

The Department expresses the view that “disclosure of privileged and/or confidential material relating to the claims ... would be inappropriate ...”. It is important to be clear that confidential material is not necessarily covered by legal privilege. In particular, while details of the settlements reached with some of the litigants may be subject to a confidentiality agreement, they will not be covered by legal privilege. Under section 7(1) of the Ombudsman Act, the Department is legally bound to provide the Ombudsman with this material - as specified in our letter of 31 August 2009 - irrespective of any view it may hold that disclosure would be inappropriate. “

In subsequent correspondence, the Department raised issues to do with fair procedure, about its need to know precisely the nature of the complaints it should address and re-stated the view that the conduct of the litigation could not be seen as having any bearing on a valid Ombudsman investigation. Furthermore, it rejected the view that it is open to the Ombudsman to consider “*the actions of the Department of Health and Children in seeking to resolve any lack of clarity regarding the intention of the legislature in enacting section 52 of the Health Act 1970*”. The Department takes the view that its actions, or failure to act, in this regard cannot be understood as actions taken in the performance of an administrative function. The Department maintained the position that it was perfectly willing to co-operate with any investigation provided the Ombudsman remained within her jurisdiction; and it pointed out that the HSE had co-operated in the provision of files on individual complainants;

but it would not provide material relating to those elements of the investigation which, in the view of the Department, were not within the Ombudsman's jurisdiction.

On **16 October 2009** the Ombudsman wrote to the Department saying, amongst other things:

- that she is satisfied that the investigation is within her jurisdiction;
- that the Department had failed to comply with a statutory requirement under section 7 of the Ombudsman Act;
- and that, notwithstanding this failure to cooperate, she intended to proceed with the investigation.

The Ombudsman also pointed out that the Department's refusal of information included much information which in principle is, or should be, in the public domain (for example, information on court proceedings). And in terms of refused documentation, she pointed out that some, in principle, is in the public domain (court pleadings, for example) while other items, such as records of costs incurred, should be in the public domain in the interests of transparency and accountability.

COMMENT

The role of the Ombudsman is set out in the Ombudsman Act 1980. The Ombudsman may investigate "any action" taken by, or on behalf of, a body subject to her jurisdiction provided the action in question is one "taken in the performance of administrative functions". Where the Ombudsman finds that the action has adversely affected a person, and that the action reflects "maladministration" ⁽⁴⁾, then she may recommend redress for the person concerned.

Taken at face value, the Department's vision of what the Ombudsman may do is limited to the investigation of individual complaints,

or groups of complaints, but focused always on the narrow issues of the specific cases. Furthermore, the Department proposes an understanding of the term "taken in the performance of administrative functions" as a narrower rather than a wider category. ⁽⁵⁾ In effect, the Department's vision of the Ombudsman's Office is that it is fine to deal with specific cases but that to look beyond these cases, and to ask why problems recur or why promised amelioration has not come about, is beyond the jurisdiction of the Ombudsman. This view of the Ombudsman role is at odds with the reality of what public sector Ombudsman Offices around the world actually do; it is at odds also with what the Irish Ombudsman has been doing for many years. It is implicit in the Ombudsman model adopted by the Oireachtas in 1980 that the role involves far more than the investigation of individual complaints; though dealing with these complaints remains the core business and provides the basis for looking also at wider systemic or governance issues. That this role is envisaged by the Oireachtas is made clear by the provision which allows the Ombudsman to conduct investigations on her own initiative (see Note 3 to this chapter).

One can understand that the Department is sensitive to external enquiry given the number of reports and investigations over the past decade which have focused on its performance. ⁽⁶⁾ One can also understand that the Ombudsman's Office has good reason to be particularly wary of the behaviour of the Department generally: in the conduct of the previous, related investigation in the late 1990s, and in discussions regarding long-stay care entitlement over a number of years in the early 1990s, the Department withheld from the Ombudsman key information which, had it been disclosed, would have led to the identification and resolution of the long-stay charges issue by at least a decade earlier than was actually the case. ⁽⁷⁾

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Taken in conjunction with its behaviour in the past, the refusal of the Department to co-operate with the Ombudsman in this investigation suggests that serious issues of transparency and accountability within the Department remain to be resolved. Furthermore, it is clear that the Department's opposition to the Ombudsman's investigation is prompted to a fair extent by its fear that the investigation "will have a negative impact on the State's conduct of the defence of the litigation". This prompts two questions; firstly, how should the State behave in defence of litigation initiated by a citizen claiming to have been deprived of a statutory entitlement and, secondly, what impact might an Ombudsman investigation actually have on the outcome of such litigation.

"What the Travers Report has revealed is even worse. The Office of the Ombudsman has been established as an independent organ of the State, specifically to protect citizens from the misuse of power by the executive branch. Not only did the Department of Health misuse its power over poor people; it actively obstructed the Ombudsman in doing his statutory duty to protect them".

William Kingston, *Studies*, 94 (376) (Winter 2005)

How should the State behave...?

The State has a legal personality and is liable to be sued as well as having the capacity to sue. In the normal course, litigation in our system is an adversarial process. Anyone choosing litigation must in general be prepared for what might be a bruising encounter, one in which lawyers on either side will do whatever is necessary (within the law and court procedure) to win the case for their client. At the same time, the purpose of the Courts is to administer justice.

In normal litigation, it is usually the case that the interests of the defendant are best served when the action fails. The State, however, is no normal litigant or defendant. Under the Constitution, all powers derive from the people and it is the people, not the State, who are sovereign. The State, by definition, must act in the public interest. One might expect that a body, such as the Department, exercising the executive power of the State in a litigation situation, would act in good faith and in the public interest. Unfortunately, given the history of its involvement in "managing" the long-stay care issue, the record of the Department is such that, at the very least, one is entitled to be a little sceptical of its intentions. Thus, it may not always be in the public interest that the State will be the winner in litigation. For example, if the agents of the State place their own interests over the wider public interest (as can happen) then it is not in the public interest that the State should win. Nor is it in the public interest that public money should be saved at the expense of meeting a statutory right: the public interest in upholding the law presumably takes precedence over the public interest in saving public money.

It would be very helpful if, in circumstances such as those arising in this report, there were a mechanism under which the Courts could give a declaratory ruling in relation to an issue affecting a large number of people and where, in the absence of such a mechanism, a high level of individual litigation would result. Such a mechanism might be confined to circumstances in which the putative defendant would be the State and/or one of its agencies. At present, there is no such mechanism and to provide for one would require legislation. Under such a mechanism, one can envisage that issues of legal privilege and discovery of documents would not become matters of controversy. On this approach, individual litigants would (for the most part) be relieved of the burden of undertaking costly and

burdensome legal actions. On the other side, there would be a stepping back from the unedifying spectacle of the State adopting adversarial and aggressive behaviour against its own citizens.

In the context of the litigation at issue here, the following would seem to be the case: the litigants may be characterised as coming from a vulnerable group within society; they are seeking vindication of what they believe to be a statutory right to nursing home care; their attempts to be given such care by the State have failed; they have generally incurred significant costs and endured serious upset in their efforts to secure their rights (as they see it). In the absence of a mechanism for a declaratory ruling by the Courts, there is a strong case that in dealing with litigation in these circumstances the State should see itself as acting, not simply in defence of its own interests (as would the typical defendant), but in the wider public interest. Taking this approach, it would be possible for the State side to facilitate a speedy hearing and adjudication by waiving legal privilege, agreeing to voluntary discovery of documents and thus speeding up the eventual outcome.⁽⁸⁾

In its submission in response to a draft version of this report, the Department chose to understand the type of comment above as a *“purported denial of the right of [the Department and the HSE] to have the issues the subject of proceedings before the Courts determined by the Courts, being the organ of government upon which the Constitution confers the sole and exclusive power to administer justice in the State.”* This is to misrepresent the comments above. Clearly, the Department and the HSE have the right to rely on the Courts to adjudicate; but they have flexibility in how they choose to conduct the proceedings. It is not always in the public interest that actions against a State body should be defended in the traditional,

adversarial fashion which typifies litigation generally. The Ombudsman’s point is that the response of a State body to litigation against it should be governed by what best serves the public interest rather than what best serves the interests of that particular body. The public

“The State pledges itself to safeguard with especial care the economic interests of the weaker sections of the community, and, where necessary, to contribute to the support of the infirm, the widow, the orphan, and the aged.”⁽⁹⁾

Bunreacht na hÉireann, Article 45.4. 1° - Directive Principles of Social Policy

interest and the interests of the particular body will not necessarily be the same.

Impact of Ombudsman Investigation

It seems the Department’s concerns about the possible impact of an Ombudsman investigation are predicated on a view that it is appropriate for the State agencies to behave in this litigation as if they were just any other defendant. As suggested above, this may not be a valid assumption. In any case, it is hard to see how an Ombudsman investigation would actually impinge on the outcome of the litigation. The Courts would be most unlikely to be influenced, one way or the other, by any legal analysis of the Health Act 1970 put forward in an Ombudsman investigation report. That analysis is unlikely to contain any insights not already ascertainable by a competent legal team acting for the plaintiffs. Similarly, insofar as an Ombudsman investigation report might comment on the overall approach to the litigation being adopted by the State, this is most unlikely to contain anything not already apparent from the pleadings of the State and which would be known already to the plaintiffs.

On the issue of other such cases having been settled out of court, the fact that this

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

has happened is already well known and an Ombudsman report mentioning this would have no bearing on matters one way or the other. Indeed, knowledge of the terms of such settlements would be most unlikely to have any bearing on a court judgment; though it would perhaps be helpful to a plaintiff interested in making such a settlement.

Wider Issues raised by Jurisdictional Challenge

The Ombudsman does not accept that the Department's challenge arises from a genuinely held belief that this particular investigation is being conducted without proper jurisdiction. Furthermore, the Ombudsman believes that the challenge, and the related failure to co-operate with the investigation, constitute a failure to comply with the requirements of section 7 of the Ombudsman Act 1980. This conclusion applies equally to the HSE albeit that it co-operated to some extent.

The refusal of the Department to give any information relating to settlements is particularly troubling. What it means is as follows:

- some plaintiffs have succeeded, at least partially, with their claims;
- public money has been spent on these settlements though the extent of this expenditure is not known;
- there is no way of knowing why these particular plaintiffs should have succeeded while other plaintiffs, presumably with broadly similar cases, have not succeeded;
- on the face of it, some plaintiffs are being treated more favourably than other plaintiffs;
- the successful plaintiffs are being treated more favourably than the thousands of others, affected by the State's failure to provide nursing home care, who have not taken legal action;
- it appears it is the intention of the Department that details of these settlements will never be disclosed.

It is probable that the insistence on confidentiality arises at the behest of the State rather than of the plaintiffs but is likely to be defended by the State on the grounds of protecting the interests (for example, right to privacy) of the plaintiffs. ⁽¹⁰⁾ The plaintiffs, having chosen to bring their cases to court, and thus into the public domain, can have no expectation of privacy or confidentiality and it would be disingenuous to suggest that the State is simply acceding to the wishes of the plaintiffs. Any attempt by the State to keep confidential the terms of settlements in these cases should be viewed in the light of the provisions of the Freedom of Information (FOI) Act 1997. It seems probable, based on existing precedents, that these settlements would be releasable under the FOI Act if sought by a requester.

The Information Commissioner has given two FOI appeal decisions dealing specifically with the right of access to out-of-court settlement agreements between a public body (co-incidentally, the HSE in both cases) and a third party. In both instances, notwithstanding that the settlements included a confidentiality clause, the Information Commissioner directed release of the settlement terms. ⁽¹¹⁾ In a decision dated 12 March 2010 the Commissioner commented:

"I wish to include here a general comment on the matter of confidentiality agreements. In my decision in Case No. 000528 ... I set out my views on confidentiality agreements in an era of FOI and expressed the belief that the enactment of the FOI Act has a bearing on the capacity of public bodies to enter into legally binding confidentiality agreements which are now subject to its implied terms. I stress that I have not said that FOI renders all such agreements inoperable, As I have previously found, section 26 of the FOI Act is not intended to protect the interests of public bodies. The language within section 26

itself, especially in sub-section (2), supports the view that the protection of the section is directed at entities other than public bodies.“
(12)

The Commissioner’s position is that, under FOI, a confidentiality clause may be invoked to protect the interests of the party other than the public body; but not to protect the interests of the public body. In the present context, it seems unlikely that the FOI Act would protect the interests of the plaintiffs. There do not seem to be good grounds for believing that the right to privacy of the plaintiffs, who have made settlements with the State, should displace the public interest in knowing the extent to which State bodies are giving public money to individual persons.

The approach of the Department and of the HSE in the present context, in refusing any information on the settlements, seems designed to frustrate the Ombudsman in the performance of her statutory duty. It seems the same intent was evident in the manner in which the HSE failed to co-operate with the Information Commissioner in her role in the decision cited above. Included in the material at issue in that FOI case was information about payments made by the HSE to a company as a result of an out-of-court settlement. It appears from the Commissioner’s published decision that the HSE withheld the relevant records from her Office until forced to hand them over following the serving of a legal requirement. The Commissioner comments on this in her decision:

“My Office encountered misleading and incomplete responses to its efforts to clarify and examine the issues and the records under review. Although the HSE’s submission of 30 November 2009 purported to present all of the material within the scope of the review, it later transpired that the records covered by item 4 of the request - the

payments made- had been omitted from the material received in response to requests from my Office on several occasions. Some of the omitted records were furnished on 4 February 2010. However, on 11 February 2010 my Office served notice under section 37 (1) of the FOI Act on Professor Brendan Drumm, Head of the HSE, requiring him to furnish the outstanding record showing the amount paid to Lifeline [the company in question] as a result of the High Court case in 2008. The record, accompanied by a submission, was received from A&L Goodbody, solicitors on 18 February 2010. No reason was given for the previous failure to supply the necessary information to enable me to carry out this review.

Unfortunately, the evidence in this case leads me to conclude that the HSE’s behaviour in relation to the request and the review had the effect of frustrating the operation of the FOI Act in relation to access to records and delaying my Office’s review and investigation into whether or not the refusal of the records was justified. “

This suggests very clearly a problem of a lack of transparency, and a pattern of willingness to frustrate statutory investigation, on the part of the HSE and of the Department.

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Notes

(1) This letter is published, along with other related correspondence, on the Ombudsman's website <www.ombudsman.gov.ie>

(2) An "own initiative" investigation, provided for at section 4(3) (b) of the Ombudsman Act 1980, is undertaken on the initiative of the Ombudsman herself rather than in response to a complaint from a specific complainant. The provision allows for an Ombudsman investigation of an "action", in the absence of a specific complainant, where "it appears to [her], having regard to all the circumstances, that an investigation under this section into the action would be warranted". While not dealing with a specific complaint or complainant, "own initiative" investigations are informed generally by complaints received. This was the case in the present instance.

(3) Section 7 of the Ombudsman Act 1980 provides the Ombudsman with the statutory power to "require" the provision to her by "any person" of information or documents in the control of that person. Section 7 also authorises the Ombudsman to require the attendance by a person who holds such information or documents. Section 7(3) provides: "A person shall not by act or omission obstruct or hinder the Ombudsman in the performance of his functions or do any other thing which would, if the Ombudsman were a court having power to commit for contempt of court, be contempt of such court."

(4) The term "maladministration" is used as a shorthand description for the seven grounds listed at section 4(2) (b) of the Act: "(i) taken without proper authority, (ii) taken on irrelevant grounds, (iii) the result of negligence or carelessness, (iv) based on erroneous or incomplete information, (v) improperly discriminatory, (vi) based on an undesirable administrative practice, or (vii) otherwise contrary to fair or sound administration."

(5) In its chapter on the Ombudsman in *Administrative Law in Ireland* (3rd edition 1998, pp.344 - 345) Hogan and Morgan express the view that the "requirement that the 'action' be 'taken in the performance of administrative functions' is designed to exclude judicial or legislative decisions." The actions of the HSE and of the Department addressed in this investigation cannot be described as either judicial or legislative. The fact that some of these actions may relate to judicial or legislative actions is of no consequence in this context.

(6) For example, the Ombudsman's *Nursing Home Subventions* report (2001), the Travers Report (2005) and the *Second Report of the Organisational Review Programme*, Department of the Taoiseach, 2010

(7) For more on this, see Chapter 5.

(8) The State is currently resisting discovery in some of the cases before the Courts - see Chapter 8 - though the HSE says it has agreed to voluntary discovery in some cases.

(9) The Directive Principles of Social Policy are stated to be "for the general guidance of the Oireachtas ... in the making of laws...". They are non-binding.

(10) In its response to the draft version of this report, the HSE (at P.16) commented that it is not "appropriate to assume that it is always the HSE who might insist on, or seek, a confidentiality agreement".

(11) See the decisions of the Information Commissioner in Case 000528 - *Sunday Times & North Eastern Health Board* and Case No. 090191 - *Sunday Times & Health Service Executive* on <http://www.oic.gov.ie>

(12) Case No. 090191 - *Sunday Times & Health Service Executive*

3. BACKGROUND...

3. Background...

Before dealing in any detail with the role of the public health service in providing nursing home care for older people, it may be helpful to set out some of the background facts and figures. While this report reflects the experience of the Ombudsman's Office since its establishment in 1984, it is relevant to note that in late October 2009 the role of the State in the provision of nursing home care was re-defined following the commencement of the Nursing Homes Support Scheme Act 2009. The account which follows deals both with the situation prior to October 2009 and with the current situation. Inevitably, the lines of demarcation between the old arrangements and the new are not always, at this stage at least, drawn clearly.

In attempting to provide an overview of nursing home arrangements over the period in question, it is difficult to avoid the question of legal entitlement which, ultimately, is the core issue considered in this report. For the purposes of this chapter, however, this question is not considered in any detail.

Both the public and the private sector are involved in the provision of long-stay nursing home care for older people in Ireland. It is difficult to provide accurate statistics on numbers of nursing home places and, in attempting comparisons over time, one

“The current system of a combination of public, voluntary and contract beds in private nursing homes along with subvented beds is distinctly inequitable. In beds side by side in a nursing home, a patient and family may have gone to considerable distress and disturbance to dispose of assets and pay to make up the difference between subvention and nursing home costs, while in the next bed a patient with similar assets may be paying nothing at all. This anomaly should be clarified immediately”

Desmond O'Neill et al in *Irish Medical Journal*, 94 (3), (March 2001)

cannot be certain that the figures available are comparing like with like. Some of the health boards and more recently the HSE have had a practice of placing public patients in private nursing homes but at the expense of the health board (HSE). These “contract” beds are often included in the overall figure for public nursing home places. For example, in September 2008, the HSE was contracting approximately 3,000 beds in private nursing homes to supplement its own stock of directly managed nursing home beds.⁽¹⁾

Notwithstanding the possible unreliability of some of the statistics, one certain development (described below) over the period covered by this report is the extent to which the private sector has replaced the public sector as the primary provider of long-term nursing home care.

As of March 2009, there were about 23,000 people in long stay residential care in Ireland. Of these, about 7,500 were in public nursing homes with about 15,500 in private nursing homes. ⁽²⁾ Of those in private nursing homes, it appears about 750 were in “contract” beds which means that, in all, 8,250 people were in publicly funded care. Roughly 5% of the over 65 population is in long-stay nursing home care.

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

In terms of nursing home units, there are currently about 600 such units, 150 of which are public nursing homes and 450 of which are private nursing homes.⁽⁹⁾ Reasons for admission to long-stay care include physical disability and social needs but the majority of older people in long-stay care are there because of chronic physical illness and dementia.

The information available suggests that the demand for public nursing home care has, for quite some time, exceeded the supply of public places. In fact, there has been a decline in publicly-funded long-stay beds over the last five decades. A 2006 SIPTU report on Care of Older People summarised the situation:

“There has been a major reduction in the number of public nursing home beds since 1968. The numbers have not only reduced in absolute terms but they have been almost halved in terms of beds per 1,000 population over 65. When the Care of the Aged Report was published in 1968, there were 42 public nursing home beds available per 1,000 of the population aged over 65 (13,594 beds for 323,000 people aged over 65). In 2001, there were 23 such beds per 1,000 population (10,067 beds for 432,000 people aged over 65).”⁽⁴⁾

The Table below summarises the situation:

| YEAR | NO. OF PUBLIC LONG-STAY BEDS | PUBLIC LONG-STAY BEDS PER 1,000 POPULATION OVER 65 YEARS |
|------|------------------------------|--|
| 1968 | 13,594 | 42 |
| 2001 | 10,067 | 23 |
| 2009 | 8,250 | 18 |

By contrast, the private nursing home sector in Ireland has expanded considerably over recent years. In fact, as illustrated in the Table below, the number of private beds virtually trebled in the twelve year period 1997 - 2009:

| YEAR | NO. PRIVATE NURSING HOME BEDS |
|------|-------------------------------|
| 1997 | 6,932 ⁽⁵⁾ |
| 2003 | 14,946 ⁽⁶⁾ |
| 2007 | 18,883 ⁽⁷⁾ |
| 2009 | 20,526 ⁽⁸⁾ |

For most of the period covered by this present report, people who needed long-stay care and who were unable to access a public nursing home bed had to rely on a system of public subvention to private care. A monthly average of 9,161 beds were reported as subvented during 2009 which meant that six of every ten private nursing home patients were then getting some level of subvention.⁽⁹⁾

Very many older people had no option other than to avail of private care and, in so doing, fared badly in financial terms by comparison with those who succeeded in getting a place in a public nursing home. In the case of a person in a public nursing home, the State paid the cost of care and charged the individual a maximum of €153.25 per week. Whereas a person, equally in need of care but not fortunate enough to get a place in a public nursing home, was responsible for meeting his or her nursing home costs with no more than the possibility of a State grant or subvention towards those costs.

Nursing Home Subvention Scheme

The nursing home subvention scheme ⁽¹⁰⁾ operated from 1993 until late 2009 when it was replaced by the Nursing Homes Support Scheme. People who, on 27 October 2009, were already receiving a nursing home subvention could opt to transfer to the NHSS or to continue to receive subvention under the existing arrangements. On the face of it, the subvention scheme was designed for people who made a conscious choice to avail of private nursing home care and who could expect some State support for the costs of this care. In principle, the scheme should have had no implications for those who wished to avail of public nursing home care. In reality there were not enough public nursing home beds and, inevitably, many older people were forced to take up places in private nursing homes where the subvention payable was inadequate.

The maximum basic payment under the subvention scheme was set initially at £120 per week but by 2009 this had increased to €300 per week. In many cases, an enhanced or top-up subvention was also paid. The circumstances in which an enhanced subvention might be paid were complex; it was stated to be available only where the HSE had the resources to pay the higher rate. In October 2006, according to the HSE, 7,563 people were in receipt of a subvention payment and 4,725 of these were also being paid an enhanced subvention payment ⁽¹¹⁾. However, these figures had risen to 9,219 and 4,826, respectively, by May 2009. ⁽¹²⁾

It is remarkable that, within these figures, there were significant differences in the level of subvention payments from HSE administrative area to administrative area and even from county to county; this variation was particularly marked in the case of the enhanced subvention. For example, while 323 people in Co. Roscommon were in receipt of a basic subvention payment in May 2009, none

of these 323 people received an enhanced subvention. By contrast, all 581 people from the three areas of Dublin North in receipt of a basic subvention on this date were also in receipt of an enhanced payment - see Table below.

Nursing Home Subventions by Selected Regions/Area - May 2009 ⁽¹³⁾

| | Basic Subvention | Enhanced Subvention | Percentage of total receiving enhanced subvention |
|-------------------------------------|------------------|---------------------|---|
| Dublin Mid -Leinster (total) | 1,823 | 862 | 47% |
| Dublin North East (total) | 1,421 | 1,370 | 96% |
| 3 areas in Dublin North East | 581 | 581 | 100% |
| West (total) | 3,306 | 817 | 25% |
| Roscommon | 323 | nil | 0% |

In addition to these arrangements, the HSE in recent years developed a Delayed Discharge Initiative (DDI) under which it (as well as the major public "voluntary" hospitals) contracted beds in private nursing homes to allow for

"This lady clearly requires nursing home care. The enhanced subvention is not meeting her needs. The anomaly is that she is entitled to a public bed and if her family decided to remove her ... and add to the increasing burden in the A & E Department she would eventually get a DDI [Delayed Discharge Initiative] bed, fully funded publicly"

Dr. A, Consultant Physician in Geriatric Medicine, in a letter to the HSE, (27 August 2007)

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

the transfer of patients to more appropriate care facilities when they no longer needed acute hospital care. Between August 2005 and March 2007, 1,499 patients were placed in nursing home care under this initiative ⁽¹⁴⁾. These placements were intended to be for a limited period of time (14-28 days) only; although the experience of the Ombudsman's Office suggests that, on occasion, individuals

“As you are well aware the constant lack of provision of extended nursing care beds in the public sector has resulted in an increasing reliance on private sector nursing home beds.”

Dr. A, Consultant Physician in Geriatric Medicine, in a letter to the HSE, (27 August 2007)

have remained in these “DDI contract beds” for several years after initial placement.

Since 2001, the provision and funding of long-stay care has attracted the attention not just of the Ombudsman but also of the Human Rights Commission ⁽¹⁵⁾, the National Economic and Social Forum ⁽¹⁶⁾, the National Disability Authority ⁽¹⁷⁾ and the Irish Medical Organisation ⁽¹⁸⁾ amongst others. Over this period also various reports on the matter have emanated

“In the current health care system older people are sometimes seen as ‘bed-blockers’ rather than patients with specific needs. When the reason for delays in discharge from the acute hospital are analysed, it can be seen that older people and their relatives are not to blame for the delays in discharge or for the ‘A & E crisis’. Instead the problem largely stems from the paucity of community services for older people and the difficulties in accessing long-term care.”

Paul Gallagher et al, *Irish Medical Journal*, 101 (3), (March 2008)

from Government departments (including the Department of Health and Children), the former health boards and the Health Service Executive.

In 2003, the Department of Social and Family Affairs commissioned Mercer Human Resource Consulting to produce the *Report on the Future Financing of Long-Term Care in Ireland*. This report examined the possible options for the financing of long-stay care. Simultaneously, the Department of Health and Children published the *Review of the Nursing Home Subvention Scheme* by Professor Eamon O'Shea which examined the objectives of the subvention scheme and the scope for achieving similar objectives by other means.

Following the publication of these reports, the Department of Health and Children agreed to undertake a review of the subvention scheme with the objective to develop an equitable and transparent scheme which would be consistent in implementation ⁽¹⁹⁾. A working group chaired by the Department of the Taoiseach was established with a view to identifying the policy options for a financially sustainable system of long-term care ⁽²⁰⁾. The resulting *Report of the Interdepartmental Working Group on Long-Term Care 2006* was published in 2008. These reports, along with the 2006 HSE - commissioned Prospectus report *Assessment of Needs for Residential Care for Older People*, have influenced thinking and planning in this area. The NHSS Act 2009 represents the tangible outcome of these deliberations.

Nursing Homes Support Scheme (NHSS)

The central role of the private sector in providing long-stay care for older people is reflected in the terms of the NHSS Act 2009 which came into effect on 27 October 2009. Under the 2009 Act, the HSE becomes just another “provider” of nursing home care and, for all practical purposes, has the same role as has the operator of a private nursing home.

For individuals entering long-stay care after 27 October 2009, the NHSS is the only system of State support for such care. It provides a scheme of financial support for people who require long-term nursing home care and is based on the principle of co-payment, that is, anyone who is assessed as in need of long-stay care makes a contribution to care costs based on means, and the balance is paid by the HSE; this is the arrangement regardless of whether the person is in a public or private nursing home. By the end of May 2010, the HSE estimated that 11,000 NHSS applications had been received and the HSE commented that “significant numbers of public nursing home beds [were] being vacated as clients move to nursing homes in the private sector”.⁽²¹⁾ In its July 2010 Performance Report the HSE stated that, up to that point, it had received 13,764 NHSS applications, 68% of which had been processed (though no figure was given for the number of applications refused).⁽²²⁾ A more detailed discussion on this Scheme can be found in Chapter 7 of this report.

Comment

A feature of public provision of long-stay care for older people in recent decades has been the absence of consistency in terms of how patients access care.⁽²³⁾ Related to this, and unfortunately the source of much frustration to older people and their families, has been the absence of any consistent approach to establishing priorities for the allocation of care places and the absence of any coherent approach to the management of waiting lists.

For example, in the HSE Dublin Mid-Leinster region, all decisions regarding the allocation of publicly-funded long-stay beds, and placements on waiting lists for such beds, were left solely with the consultant geriatrician(s) in that area, regardless of the financial circumstances of the individual concerned. However, in the HSE Dublin North East region it appears the practice has been that a

“I wish to advise you that public bed placements are allocated on a priority basis. Persons in the community, or who have been admitted to acute hospitals, are identified on a daily basis as requiring long-term care. Such persons may have been the victims of elder abuse, have no relatives or do not have the capacity to take care of themselves, for example. These persons take priority over and above others who are on the waiting list, but are already in long term care in private nursing homes.”

HSE (Dublin North East) official in a letter to the Ombudsman’s Office, (17 November 2009)

person might be placed on a waiting list for a publicly-funded bed on financial grounds (often regardless of the medical circumstances) if there was a shortfall between the cost of private nursing home care and the combination of the person’s income and nursing home subvention.

Indeed, under the arrangements in place prior to the NHSS, placement on a waiting list for publicly-funded care was far from being a guarantee of actually securing such care. In fact many individuals who entered private nursing home care, in the expectation of a publicly-funded bed later on, were disappointed to find their place on the waiting list usurped

“Long term care for the elderly has been privatised by stealth. The number of beds designated for geriatric patients has reduced. Incidentally, this parallels the reduction in acute hospital beds. Funded through capital allowances and nursing home grants, the role of caring for the elderly has been passed to the private sector, imposing huge financial burdens on patients and their families. Other elderly patients are being retained in acute hospital beds either because they are not suitable for or cannot afford private nursing home beds.”

Irish Medical Organisation, Pre-Budget Submission 2005

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

by others who, although in similar financial circumstances, were considered a priority by the HSE because they were then occupying an acute hospital bed. When one such case was investigated by the Ombudsman she found that there had been a delay on the part of the HSE of more than eight years in processing an application for a public nursing home bed; she found that this delay had affected the family concerned adversely and she recommended financial redress, totalling €56,500, for the family. The HSE accepted the Ombudsman's recommendation in full. ⁽²⁴⁾

For many people, the only route into long-stay care has been through the acute hospital system. Few acute hospitals have designated long-stay beds, so for most the discharge process into long-stay care, whether to public or private facilities, is central to the freeing up of hospital beds.

However, in the absence of equitable and timely access to appropriate long-stay care - especially as funding options through subvention had decreased significantly in recent

2008 paper reported that 50 out of 90 patients surveyed over a two year period in a 258 bed acute general hospital (not identified) were awaiting a long-stay care bed taking up 1,729 bed days ⁽²⁵⁾. In June 2009, it was estimated that 144,565 bed days were lost nationwide due to delayed discharges ⁽²⁶⁾. This so-called "bed-blocking" has attracted much comment over the years with reports of hospitals "bursting at the seams" with up to a thousand patients at any one time nationwide awaiting discharge from acute hospitals to long-stay care ⁽²⁷⁾.

The NHSS, in operation now since late October 2009, represents the State's considered response to the difficulties outlined above.

"There are no clear rules about how people are allocated public places. Since everyone is eligible to get a public place and since there are not enough places available there must be some system for deciding who gets a place. In spite of the requirements of the Freedom of Information legislation, the former health boards gave very little information about how they allocated places. This has led to a perception that places may be unfairly allocated."

Ita Mangan in *Care of Older People*, SIPTU, (May 2006)

times - individuals often remained in acute hospitals for lengthy periods whilst awaiting placement in long-stay care, using up valuable "bed-days" in the process. For example, a

Notes

- (1) PQ 34330/08, (20 October 2008)
- (2) PQ 28914/09, (9 July 2009)
The figures quoted in this chapter relate to older people in long stay care; they do not include those in residential care for reasons of disability or other chronic conditions. In 2009 there were 8,997 adults with disabilities in residential care (Source: *Report of the Comptroller and Auditor General 2009* - Para. 45.2).
- (3) Interview with Noel Mulvihill, HSE Assistant National Director for Older Persons, *Irish Times* (17 August 2010)
- (4) <http://www.siptu.ie/retired/Publications/FileDownload,3992,en.pdf>
- (5) PQ 3789/05 (8 February 2005)
- (6) *Annual Private Nursing Home Survey 2007*, Nursing Homes Ireland, (2007).
- (7) *ibid*
- (8) PQ 28052/08, (9 July 2009) - reply from HSE is dated 11 September 2009
- (9) PQ 28914/09
- (10) The subvention scheme was provided for in the Health (Nursing Homes) Act 1990 while regulations for qualification and assessment for subvention were provided for in the Nursing Homes (Subvention) Regulations 1993 (S. I. No. 227 of 1993).
- (11) PQ 16011/06, (17 January 2007)
- (12) PQ 25086/09, (30 June 2009)
- (13) *ibid*. These variations, and other aspects of the operation of the enhanced subvention arrangements, were considered in some detail in an Ombudsman investigation report **Ten Complainants about Nursing Home Subvention Payments and the HSE** (September 2010) available at <http://www.ombudsman.gov.ie/en/Reports/InvestigationReports/ThreeInvestigationReports-September2010/>
- (14) PQ 10938/07, (22 March 2007)
- (15) *Older People in Long-Stay Care*, Human Rights Commission, (November 2002)
- (16) *Care for Older People*, National Economic and Social Forum, (November 2005)
- (17) *Response to Human Rights Commission Consultation Document on Older People in Long-Stay Care*, National Disability Authority, (July 2003)
- (18) *Position Paper on Care of the Elderly*, Irish Medical Organisation, (January 2006)
- (19) PQ 26095/03, (11 November 2003)
- (20) PQ 35393/05, (22 November 2005)
- (21) HSE Performance Report, May 2010 <http://www.hse.ie/eng/services/Publications/corporate/May2010PR.pdf>
- (22) HSE Performance Report, July 2010 <http://www.hse.ie/eng/services/Publications/corporate/july2010performancereport.pdf>
- (23) In its response to the draft version of this report, the HSE comments (at P. 5): "*The main reason why there was not a standard approach was because, prior to the establishment of the HSE, health boards were separate legal entities and different systems were in place in different areas throughout the country.*"
- (24) Ombudsman investigation report **The Ombudsman and the HSE West Investigation Report** (September 2010) available on the Ombudsman website at <http://www.ombudsman.gov.ie/en/Reports/InvestigationReports/ThreeInvestigationReports-September2010/>
- (25) *Do relatives of elderly patients block the discharge process?* P. Gallagher et al., *Irish Medical Journal*, 101 (3), (March 2008)
- (26) PQ 29669/09, (9 July 2009)
- (27) *Sunday Business Post*, (20 September 2009)

4. WHAT COMPLAINANTS SAY...

4. What Complainants Say...

The health boards became subject to the jurisdiction of the Ombudsman on 1 April 1985. Almost immediately, complaints about long-stay care began to come in. Initially, the numbers were relatively small but after 1990 those numbers increased significantly. Over the past 25 years the Office has received at least 1,200 complaints, or an average of 48 per year, involving nursing home type care. ⁽¹⁾ From an early stage also the Ombudsman began to draw attention to these complaints in his Annual Reports to the Oireachtas.

This chapter takes a look back at complaints regarding long-stay care made to the Ombudsman since 1985. The chapter concludes with a representative sample of those complaints. What is striking, in taking this look back approach, is the extent to which the same type of complaint came to attention, year in and year out, from 1985 until 2010.

This chapter looks also at the manner in which the health boards (HSE) and the Department dealt with the Ombudsman in relation to these complaints over that period. In the light of the findings of the Travers Report, it is clear that the health boards and the Department withheld critical information from the Ombudsman over much of the period. This failure to provide all relevant information was particularly significant in the case of the Ombudsman's 2001 report *Nursing Home Subventions*.

Hardship

Perhaps the first issue to emerge was the hardship caused to families when health boards imposed charges for long-stay care in public institutions in circumstances in which there was no legal right to impose such charges. Prior to the Health (Amendment) Act 2005, there was no legal basis for charging a patient for long-stay care where the patient had a medical card or, where there was no medical card, the patient had a dependant. Despite the relatively clear legal situation, health boards persisted in charging in many instances in which the patient either had a medical card, or had dependants, or both. Ombudsman Annual Reports for 1988, 1989, 1991 and 1994 dealt specifically with complaints in this area - all of these reported complaints were upheld by the Ombudsman and the relevant health board conceded that its actions were incorrect.

Hardship for families was an issue also in cases in which a family member ended up in private nursing home care and the family could not afford the costs of that care. The Ombudsman's Annual Report for 1990 outlined a case in which an elderly complainant was left below the poverty line, as measured by the weekly rate of Supplementary Welfare Allowance (SWA), because he was paying out most of his old age pension towards the costs incurred by his wife (a stroke victim) in a private nursing home. The pensioner made this complaint in 1989 (see **Complaint Miscellany**). It was clear that he had not chosen private care for his wife and that she was in a private home simply because she could not get a place in public care. His disposable income, after contributing to his wife's nursing home costs, was £12 per week below the minimum income guaranteed by the SWA scheme. The case was resolved when the health board, following pressure from the Ombudsman, increased the subvention it was paying to a level which allowed the pensioner retain an amount equivalent to the weekly SWA rate.

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

What is of interest is that it took a few years for the issue to emerge of the health boards having a statutory obligation to provide nursing home care. The corollary of this was that patients should go into private care only where they had made a conscious decision to do so - rather than being forced into private care because of the non-availability of public care.

Annual Report 1992

In his Annual Report for 1992 the then Ombudsman included a substantial piece dealing with the legal and human issues raised in the nursing home complaints he was receiving. Looking back at a series of complaints over the previous two years, the Ombudsman identified some issues and themes which, unfortunately, have continued to be a feature of complaints in this area in each of the 18 years since then. Observing that having to place an older family member in long-stay care is always traumatic, the Ombudsman commented that this trauma is added to considerably by what he perceived as a “*lack of clarity regarding the elderly person’s entitlement to long-term care and regarding the financial and associated arrangements which need to be made*”. The Ombudsman remarked that “*there can be a great deal of confusion regarding entitlements and financial arrangements at this difficult time*”. In the light of developments subsequently, it is worth quoting what the Ombudsman said at that point in his 1992 Report:

“The common thread in all of these complaints is an absence of information and a general lack of clarity regarding the health boards’ obligations in respect of such long-stay patients. In the case of some of the boards concerned, it would appear that the situation is made worse by the shortage of long-stay beds and the resultant need to place patients in private nursing homes. It would appear that patients and their families

are not being informed of the statutory obligation on the health board in relation to such cases and, accordingly, do not have accurate information regarding the financial implications of this situation.

From my examination of these complaints to date, I am satisfied that these elderly patients would be considered to be in need of “in-patient services” and that this is a service which health boards are statutorily required to make available...

At present, health boards can meet their obligation either by caring for patients in their own institutions or, alternatively, by placing their patients in private institutions (e.g. nursing homes) under a contract arrangement. Whatever arrangement health boards make for their patients, the essential fact is that they are obliged to ensure their patients receive the service to which they are statutorily entitled. In some situations health boards may impose a charge for the provision of in-patient services. However, a charge may be imposed only after 30 days, and only where the patient has no dependants. Furthermore, where a charge is to be imposed, this charge is determined by reference to the income of the patient only; there is no statutory provision to have regard to the income of other members of the family.

[...]

In the complaints I received the patients and their families were encouraged by the health board concerned to make arrangements with private nursing homes. In doing so, it would appear that some health boards did not explain their own legal obligations and encouraged the view that they had little, if any, responsibility for such patients.

In the cases I have examined typical private nursing home fees range between £150 and £200 per week. The typical patient would

have a pension of about £65 per week leaving a shortfall of £85-£135 per week. The health board, for its part, would in certain cases, pay a weekly subvention of about £40. However, this subvention is payable subject to a means test which has regard, not only to the income of the patient, but also to the financial circumstances of the patient's wider family. Even where the £40 subvention is paid - and it was not paid in all the cases I have seen - there would be a weekly shortfall of between £45 - £95. This shortfall would have to be met by the patient's family. For very many families, meeting this shortfall is a crippling financial burden.

There would appear to be no statutory basis for a means testing system which includes the income of the family as well as that of the patient.

In the course of examining these complaints one health board involved acknowledged that such patients are entitled to be provided with in-patient services. Furthermore, the health board said it intended to meet its statutory obligation "subject to availability of resources". I take this to mean that the health board is not able to meet its statutory obligation from within its existing financial allocation. However, this health board appears to have continued its practice of encouraging patients into private nursing home care without alerting them to their existing statutory entitlements."

In 1992, therefore, we see that the Ombudsman had identified and put on the public agenda all of the difficulties which have plagued this area of public service in every year since. Confusion, lack of information, failure to provide statutory entitlements, inconsistency, use of means tests without a legal basis – these were and remained the hallmarks of the State's response to those in need of long-stay care. Unfortunately, there was very little

reaction to the Ombudsman's Annual Report piece of 1992. The Report was debated in the Seanad in September 1993 but none of the contributors referred to the detailed comments on the nursing home issue. The Report was not debated in the Dáil but was referred to by the Minister for Health in a written reply to a PQ (22 June 1993) when the Minister said:

"I am aware of the comments of the Ombudsman in his report for 1992 about the provision of services in private nursing homes for persons eligible for services under section 52 [of the Health Act 1970]. The implications of his comments are being examined by my Department in the context of the Health (Nursing Homes) Act, 1990 which will be implemented shortly."

In the event, the implementation of the Health (Nursing Homes) Act 1990 went ahead without any apparent regard to the issues raised by the Ombudsman. In fact with changing demographics, changing family arrangements and, perhaps, increased expectations for services, it is fair to say that the problems identified by the Ombudsman got worse, rather than better, as the years went by.

“Persons who, while maintaining themselves at home had full eligibility under the Health Act, 1970, may be regarded as not coming within that definition while they are being maintained in long-stay care and may, therefore, be subject to the appropriate long-stay charge. ... a full review of the regulations governing long-stay charges is at present in progress in my Department.”

Mary O’Rourke T.D., Minister for Health,
Response to PQ, (17 December 1991)

Illegal Charges

An issue raised consistently in complaints was the widespread practice within the health boards whereby people with medical cards, which provided entitlement to long-stay care without charge, were treated as if their medical cards were either withdrawn or suspended once they had been given a place in a public nursing home. Having withdrawn or suspended the medical card, health boards were then able to justify charging medical card holders for their public nursing home care. The health boards defended the practice on the basis that this was the advice given to them by the Department in a 1976 Circular. The Circular

“The South Eastern Health Board is endeavouring to deal with the complaint that was received by the Ombudsman [re. charging medical card holders for long-stay care]. ... As you are aware, I have sought legal advice on the issue. The Board has received this legal advice and were advised to seek definitive guidance from the Department of Health and Children before proceeding on the matter. The Board have had discussions with the Department on the advices received. The Department have indicated that they have legal advice, which contradicts the Board’s legal advice. This is now being studied by our legal advisors.”

South Eastern Health Board letter to the Ombudsman, (14 February 2003)

said that, in the case of a person maintained in a public nursing home, it was open to a health board to regard such a person as not coming within the definition of “full eligibility” (medical card status) and that charging was, therefore, authorised. The fact that the practice had the blessing of the Department, and had been in operation since 1976, suggested that the practice was legally sound.

The Ombudsman, however, was concerned with the legality of this practice and raised it consistently with the health boards and with the Department over many years. The Ombudsman, perhaps naively in retrospect, stopped short of finding against the practice on the assumption that the Department, before issuing the Circular, would have sought advice on its legality.⁽²⁾

The practice of withdrawing medical cards from people in public nursing homes took a new twist in 2001. In that year the Health Act 1970 was amended so as to provide medical cards (“full eligibility”) for all aged over 70 years without reference to a means or hardship test. As had been the case over the years, the Ombudsman continued to receive complaints on behalf of people who were being charged for public nursing home care even though they had medical cards. Being over 70 years, these patients were now entitled to a medical card irrespective of income and irrespective of their capacity to provide for their own GP, drugs and hospital services. In these cases, the health boards did not have the discretion to withdraw or suspend the patient’s medical card. In pursuing these complaints, with the South Eastern Health Board (SEHB) in particular, the Ombudsman’s Office argued that - whatever the position before 2001 - the health boards certainly did not now have the right to withdraw a medical card from a person over 70 years and that, accordingly, neither could the health board charge such a person for public nursing home care.

In the course of dealing with these complaints, the SEHB sought legal advice on the argument raised by the Ombudsman. It is clear that the advice provided to the SEHB supported the Ombudsman's position with the adviser commenting: *"We are not aware of any statutory justification for the practice of removing medical cards from patients in receipt of long-term care."* ⁽³⁾ However, in its response to the Ombudsman, the SEHB said in February 2003 that the Department had *"indicated that they have legal advice, which contradicts the Board's legal advice. This is now being studied by our legal advisors."* Attempts to reconcile the opposing legal positions resulted in a stalemate which, ultimately, was broken only when the issue of illegal charging of long-stay patients became a major political issue towards the end of 2004. At that point, the Minister for Health and Children accepted unequivocally that the practice of withdrawing medical cards, and imposing charges for long-stay care, was illegal and had been illegal since 1976.

All of these issues were thrashed out in considerable detail in 2005 by way of the Travers Report, within the Houses of the Oireachtas, and ultimately in a Supreme Court judgment on the constitutionality of the Health Amendment (No. 2) Bill 2004. This Bill was found by the Supreme Court to be unconstitutional in so far as it purported, retrospectively, to validate charges already imposed and which, at the time of imposition, were illegal. It is unnecessary to re-visit these matters here in any great detail.

What remains deeply puzzling is the apparent claim of the Department, in its dealing with the SEHB in 2003, that it had legal advice (presumably from the Office of the Attorney General) to the effect that the practice of withdrawing medical cards, of people placed in long-stay care, was legal. As we now know, again thanks to the Travers Report, not only did the Department not have legal advice

"Over 300,000 people were charged illegally during 28 years. This was entirely wrong. They were old, they were poor, they suffered from mental illness, they had intellectual disabilities, they were physically disabled. As vulnerable people, they were especially entitled to the protection of the law and to legal clarity about their situation. [...] We are a society ruled by law. No-one and no organisation can dispense with or alter a law."

Statement by Mary Harney T.D., Minister for Health and Children, on publication of the Travers Report, (9 March 2005)

supporting this practice, it had legal advice very firmly condemning it. This legal advice, as disclosed in the Travers Report, came not just from the Department's in-house legal adviser but from two external Senior Counsel (one of whom subsequently went on to become Chief Justice).

We know now that the actions of the Department and of the health boards were prompted by a very serious shortfall in health funding and by the need to retain a source of revenue by continuing the practice of charging all long-stay patients. This, however, does not excuse the dissembling of the Department and of the health boards in failing, over a twenty year period (1985 - 2005) of involvement with the Ombudsman, to reveal that their practice in this regard was contrary to legal advice. This is not to suggest that public authorities should allow important decisions to be made for them by legal advisers – based on the Ombudsman's experience, there may now be a tendency within the public health service to defer excessively to legal opinion – but it is the case that a public body should be very careful in its rejection of legal advice, particularly where that advice is repeated over a period and has been provided by a number of different advisers. It is true, as pointed out by the HSE ⁽⁴⁾, that the health boards did raise concerns over the years with the Department regarding these charging

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

arrangements. To this extent, the health boards' culpability may be seen as of a lesser order than that of the Department. It is very unfortunate, however, that the health boards did not act on the basis of these concerns.

Ombudsman Response to Travers Report

The Ombudsman responded to the information disclosed in the Travers Report by way of a submission, made on 3 June 2005, to the Oireachtas Joint Committee on Health and Children. This submission is particularly relevant in the present context and, for that reason, this lengthy extract is set out below:

"From the late 1980s onwards, the Ombudsman dealt frequently with complaints about the entitlement of medical card holders to long-stay hospital services. Many of these cases concerned elderly people receiving what is now being termed 'nursing home' care; some concerned people, not necessarily elderly, in long-stay care because of a psychiatric condition or some long-term debilitating illness. The complaints related to the fact that these patients were being charged despite the fact that they had medical cards and/or despite the fact that they had dependants. In many instances, the health board concerned would have revoked the medical card of the patient - though not on the basis of a proper and procedurally fair process. The Ombudsman's thinking on these cases was (a) that the type of care being provided constituted an "in-patient service"; (b) that such a service should be provided, as a matter of right and without charge, to medical card holders and to people without a medical card provided they had a dependant; and (c) that the practice of removing a medical card from a person, once hospitalised, was not tenable.

The Ombudsman discussed these matters frequently with the particular health boards

involved and with the Department centrally. The logic of this approach was that, without the support of the Department, the individual health boards were not likely to change their practice. What actually happened was that health boards, often with the encouragement of the Department, changed their practice in particular cases; but, as is now well known, the impugned practices continued generally and the law was not changed to validate those practices.

During those years, the Ombudsman drew attention to these matters by way of items in his Annual Report to the Oireachtas. Annual Reports for the years 1988, 1989, 1991, 1992 and 1994 dealt specifically with the issue. The matter was referred to as a related issue in the report 'Nursing Home Subventions' (January 2001) but it was something which the then Ombudsman very explicitly raised in his oral presentation to this Committee on 21 June 2001. Annual Reports for 2002 and 2003 again reported cases in which these matters figured. By any reckoning, this was an exhaustive effort to draw attention to practices which the Ombudsman believed to be invalid.

What we now know, arising from the Travers Report, is that throughout this extended period the Department and, to a lesser extent the health boards, had solid and uncontroverted evidence to support the position taken by the Ombudsman. Very regrettably, the Ombudsman was never made aware of this evidence.

The Travers Report shows the following:

- that in **June 1976** the Department received legal advice that a person with a medical card (full eligibility) could retain eligibility for in-patient services irrespective of how long hospitalisation lasted; and that a hospital patient could only have a medical card removed where the health board was satisfied that the patient could provide general practitioner services for himself and his dependants; [Para. 3.4]

- that in **July 1977** the Department received legal advice that its Circular 7/76 “would not stand up in court” in so far as it encouraged health boards to remove the medical card from long-stay patients; [Para. 3.7]
- that in **July 1978** the Department received, via the Eastern Health Board, the legal advice of two eminent Senior Counsel which confirmed the opinion of July 1977; [Para. 3.10]
- that, over the years, the Department’s legal adviser expressed dissatisfaction with the Department’s continued reliance on Circular 7/76; [Para. 3.13]
- that an internal Departmental review of **January 1982** acknowledged the legal invalidity of the practices in question; [Para. 3.14 - 3.16]
- that in **February - March 1987** the then Minister for Health brought a Memorandum to Government with a legislative proposal to deal with the matter; [Para. 3.17 - 3.22]
- that in **August 1992** the Department produced a report entitled ‘Review of Long Stay Charges Report’ which again acknowledged the legal invalidity of the impugned practices. [Para. 3.25]

The Department omitted to inform the Ombudsman of these crucial developments and related legal advice. Disclosure of this information would have established, in the language of section 4 of the Ombudsman Act 1980, that the Department’s actions (and those of the health boards in reliance on the Department’s position) were being ‘taken without proper authority’.

In its discussions with the Ombudsman, the Department purported to have been unaware of the Supreme Court judgment in the *McInerney* case. (This judgment established that persons in long-term care, in health board institutions which provided nursing and other para-medical care, were receiving ‘in-patient’ services as defined at section 51 of the Health Act 1970. Persons with medical cards were, at that

stage, entitled to ‘in-patient’ services without charge.) Whereas at one point it appeared to accept the Ombudsman’s analysis in full, it later resiled from its acceptance of a key aspect of that analysis and refused to accept that the Health Act 1970 conferred a legally enforceable entitlement to in-patient services.

[...]

Had the Ombudsman been aware that the Department had been provided, over successive years, with definitive legal advice on the matter, and been aware that the analysis he was offering was no more than that already provided to the Department by its own and health board legal advisers, he would have reported to the Oireachtas on the matter both more fully and more definitively. He would also have drawn the weight of evidence to this Committee’s attention when he appeared before it on 21 June 2001. Furthermore, in dealing with complaints in this area, it is very likely that the Ombudsman would have completed investigations and made recommendations providing for appropriate redress. However, in a situation in which he did not know of this evidence, and despite the strength of the argument he was himself making, the Ombudsman stopped short of making recommendations in individual cases.

If it had been possible to provide the Oireachtas with a detailed analysis as outlined above, it could have ensured that the necessary legislative steps would have been taken either to validate the existing practice or to provide a valid legal alternative. Had the matter been resolved in 1991- 1992, when there were intensive discussions between the Department and the Ombudsman, a very substantial portion of the overpayments (now required to be refunded) would never have arisen.”

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Complaint Miscellany 1985 - 2010

The extracts reproduced below are taken mostly from Ombudsman complaint files and are based on letters from complainants or from file notes by an Ombudsman case worker. While we have no reason to believe that the claims made by complainants were not made in good faith, the Ombudsman is not saying that each claim has been investigated and found to be accurate. The extracts are intended to illustrate the situations in which complainants found themselves.⁽⁵⁾

► 1986

Ombudsman Caseworker Note, (3 December 1986)

"Her mother is in [a private nursing home]. Costs £20 per day i.e. £600 for 30 day month... mother's Garda Widow's Pension of £400 does not cover this and daughter pays the rest. Has tried to get Health Board subvention and can't understand why it is not coming through. ... She told me her husband is on £62 Invalidity Pension ... and she is on £45.80 Disability Benefit ... Their 17 year old son is left school and won't qualify for anything until he is 18 years ...of this income they have to meet the shortfall of £50 to £55 per week for the Nursing Home.

[...] She said her mother is happy in [the private nursing home] and would die if she had to move to another. Whatever happens, they will starve themselves rather than move the mother who is aged 88. She looked after her for as long as she could but now she needs nursing care.

I told her that her only hope short-term was to apply for Supplementary Welfare Allowance for themselves. I said I'd check to see if anything could be done to help."

► 1989

Letter to Eastern Health Board Appeals Officer (20 July 1989)

"I am in receipt of a contributory old age pension at £93.00 per week. My wife, Mary, is in X Nursing Home on X Road, which costs £130 per week. I asked the Community Welfare Officer ... for help with this, and they got the Nursing Home Section in St. Mary's Hospital to increase the grant to the nursing home to £65.00 per week. This means that I also have to pay £65.00 per week to the nursing home, leaving me with only £28.00 to live on. Out of this I have to feed and clothe myself, pay bills, and also buy essentials for my wife and sometimes a few "luxury" items like diabetic orange and sweets.

I went back to [the] Health Centre, but they said they couldn't help and to contact the Nursing Homes Section again. My Social Worker wrote to them, but they said they couldn't help either."

► 1990

Ombudsman Caseworker Note, (21 May 1990) - withdrawal of medical card for person in long-stay care

"... persons with full eligibility are entitled to hospital in-patient services free of charge. ... As charges are being imposed [in this case], the grounds for so doing would seem to be that on entering hospital they cease to be persons with full eligibility. The rationale for this is presumably that while they are in hospital they are no longer persons who, without undue hardship, are unable to arrange general practitioner, medical and surgical services for themselves and their dependants as required by Section 45(l) of the Act i.e. for the duration of the hospitalisation

these services are provided for them by the hospital. This is the kernel of the issue. The question is: have the health boards the legal right to alter a person's status on their entering hospital i.e. to decide that a person is no longer a person with full eligibility who is entitled to hospital in-patient services free of charge but is now a person with limited eligibility who can be charged after 30 days if there are no dependants. I would suggest that the health boards do not have such a right. [...]

I find it incongruous that when that person comes to avail of the service a second decision is then taken that they no longer have full eligibility. ... It would seem that the health boards are ignoring the provisions of the legislation and the question of their actions being ultra vires must arise."

▶ 1993

Ombudsman Case Worker Note, (16 August 1993)

[The complainant Ms.Y was looking after her elderly mother at home; her brother, who was about to be discharged from an acute hospital, needed residential care; the complainant was being pressurised by the hospital to take her brother home. This is a note of a discussion with an Eastern Health Board (EHB) doctor with the role of Co-ordinator of Services for the Elderly.]

"Dr. X told me that she has advised Ms. Y not to allow [the] Hospital to pressurise her into taking her brother home when she clearly is unable to look after him. Dr. X accepts that Ms. Y is under intense pressure from [the] Hospital to take her brother away.

Dr. X confirmed almost all of the detail given by Ms. Y in her letter to us. In particular, she

confirmed that Ms. Y suffered greatly while trying to cope with both her brother and her mother and that her own health is at risk. Dr. X mentioned that the family doctor has also been making every effort to have the matter resolved but has failed.

In the course of my discussion with Dr. X it became clear that she had no understanding whatever of the obligation on the health board to provide long stay care for patients such as [Ms. Y's brother]. She said she had seen the Irish Times piece by Pádraig Ó Móráin which summarised comments made by the Ombudsman. She asked to be sent a copy of the Ombudsman's comments. She agreed that neither the EHB nor [the] Hospital would have advised Ms. Y that it was open to her brother to seek to have the EHB provide for his long stay needs under Section 52 of the Health Act 1970. Indeed she did not know that this was the case herself."

▶ 1994

Annual Report of the Ombudsman, 1994

[Health boards, with the encouragement of the Department of Health, had a practice of settling the individual case where challenged about an illegal charge for long-stay care but continued with the illegal practice otherwise.]

"A woman, whose husband had been hospitalised for almost a year, complained that she had been requested by the hospital to pay a sum of £40 weekly for his maintenance. Her complaint related to the difficulties she was having, as a dependant on her husband's Social Welfare pension, in maintaining herself and her home on the balance of the pension. In an initial contact with the Health Board on the matter, my investigator pointed out that the circumstances as outlined suggested that no

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

charge should apply. The man in question had a medical card and he had a wife who was a dependant on his pension. Health Regulations exempt such a category of person from in-patient charges.

The Health Board responded that, by imposing a charge determinable by reference to domestic financial commitments, they were acting in accordance with legislation. Eventually, the Board conceded that such a legislative basis did not, in fact, exist but they continued to defend the practice by claiming to have the right to charge for maintenance. They also claimed that the residue of pension available to his wife was reasonable.

I became very concerned at the apparent failure of the Health Board to recognise that the statutory provisions specifically precluded charges in the circumstances of the complainant and that this imposition had resulted in continuing difficulty for the woman in question. Following the intervention of the Department of Health, at my request, the Health Board informed me that the case had been reviewed and that the maintenance charges had been raised in error. They said that they would cease the practice immediately and that all charges paid would be refunded."

▶ 1996

Ombudsman Case Worker Note, (6 June 1996)

"Complainant's wife, Mary, has been in a nursing home since 16/6/94 following a serious illness. She is 83 years old as is complainant. Initially the fees were £130 pw but were raised to £170 pw from 1 January 1996. An application for subvention, made before his wife went into the home, was refused. Complainant appealed this unsuccessfully. When the fees increased in January 1996 he again applied but was refused. An appeal was unsuccessful.

The health board takes the view that his married daughter, who lives in X, is able to subsidise the costs. Complainant rejects this as his daughter has been gone for 26 years and is independent of her parents. In fact, the daughter does contribute by meeting all the extra costs (his wife is doubly incontinent) - clothing, equipment, laundry etc. and also travels regularly to see her mother. Complainant says that, after paying the nursing home fees, he has only £35 pw to live on - and this is inclusive of the income tax relief for medical expenses. He says he runs a car as it is the only way he can get to visit his wife - whom he visits four times a week. Whatever savings they had are being gradually eroded and they will not have sufficient to bury themselves, he feels."

▶ 2001

Complainant Letter to Ombudsman, (18 February 2001)

"...my mother has been in the [private] Nursing Home for the past 10 years. She is a widow with no assets (she only had a rented house). She is just 93 years of age. ... As a family we have been making up the shortfall [between nursing home fees and health board subvention] for the past 10 years. My husband and I are both over 60 years of age, and he needs to retire shortly. I am a full-time housewife and do not work myself. In the past 12 months we have paid over £6,500 to the [nursing home]. During the course of the past 10 years it has cost us over £35,000 and all our savings have disappeared.

At present we are trying to place my mother in a cheaper nursing home but unfortunately due to her age, infirmity and dependence it is proving very difficult."

► 2005

Ombudsman Caseworker Note, (11 March 2005)

“His late mother had been in a private nursing home for three years from 1999 to 2002. She had a medical card and was over 90 years of age when she died (R.I.P.) in August 2002. Mr.X had no option but to put her in a private nursing home as there were no public beds available. She was getting a subvention from the [health board], handing up her pension and he (Mr. X) had to make up the shortfall in nursing home fees. In order to do this he had to vacate the family home and rent it out. His only income was his Contributory Old Age Pension. He is 76 years old now. He went to stay with friends and paid rent there. While his mother was in the nursing home he had just finished a course of chemotherapy for a tumour on the lung. He had been attending Hospital for check-ups and treatment.”

► 2007

Complainant Letter to Ombudsman, (5 October 2007)

(This complainant says she was forced to place her mother in private care because of the unavailability of public care. After six years, her mother was given a publicly funded bed.)

“In December 2005 the HSE finally provided a contract bed for her in ... this happened after 6 ½ years of negotiation. [...]

*The situation of public versus private care is totally and utterly discriminatory. Can you please explain to me the difference. My neighbour has a loved one in a public Care Centre and I have my mother in a private home. My neighbour is being paid back** for being*

overcharged by the State and in my position this is being refused to me just because the State forced my mother into private care because they couldn't provide it. This is totally discriminatory to the Constitution of this State which states all citizens are of equality.

I don't know if the Office of the Ombudsman can take this case forward ... to recover our losses ... which stand between €80,000 and €85,000. If this can't be progressed via these means the only way forward is through the courts.”

** This is a reference to the Health Repayment Scheme under which people, charged illegally for long-stay care in public institutions, are entitled to have those charges refunded with interest. The complainant's point is that people who failed to find a place in a public institution, and who had no option but to go into private care, are doubly disadvantaged: (a) because of having to pay very high nursing home costs and (b) because they are excluded from the benefits of the Health Repayment Scheme.

► 2009

Complainant E-mail to Ombudsman, (5 July 2009)

(This complainant's mother has a serious illness for which she requires long-stay nursing home care. But because her mother is under 65 years, she is not able to avail of HSE services for older people and has not been able to access public nursing home care.)⁽⁶⁾

“My mum has no property and no other income but her social welfare so she qualified for the full subvention of 340 euros a week and I've to make the difference i appealed it straight away to be told 6 months later when i was growing concerns of lack of finances at home how i was going to pay for my mums care and applied for

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

an enhancement payment of which i haven't heard of anything back of yet.

At present I'm finding things very difficult keeping up my job and bills and our mortgage with my husband not with regular employment and I've tried to get hse care for my mum and she doesn't qualify because she doesn't fall into the elderly until she's 65 there is nothing or no services for her illness even ... I don't know how much more of all this i can take emotionally or physically my children are suffering emotionally with me not here i know i am going to have to give up my right to contribute for her care as i cant afford it and don't want to loose my home because of my lack of funds and how will i pay to Berrie her that was to come from her savings and there nearly gone, i don't know what will happen if i have to do this and its a horrible thing to have to do but it looks like my only option."

Notes

(1) This figure is probably an understatement of the true extent of the complaint numbers in this area. It is difficult to establish accurate figures at this stage given that in the early years of the Office files were not computerised and complaint category codes were less specific than in later years.

(2) We know now from the Travers Report that the health boards and the Department were aware from the outset that this practice was not legally defensible.

(3) Quoted in the Travers Report, para. 3.35 (iv)

(4) In its response to a draft version of this report the HSE points out (at P. 6) that the health boards had concerns *“around the legality of raising such charges and raised these concerns on a number of occasions [between 1977 and 2003] with the Department ...”*. The HSE points out also that the health boards asked the Department to seek the advice of the Attorney General (AG) following on from legal advice provided to the South Eastern Health Board in 2003. Ultimately, the HSE points out, the correctness of the SEHB advice was confirmed by the AG; this was in late 2004.

(5) Both the Department and the HSE in their submissions have taken issue with the inclusion of this material. The HSE says that it is difficult to comment on the cases as the individual complainants have not been identified - though it does comment on five of them. The Department is critical of the Ombudsman's reliance *“upon complaints which, it is conceded, were not investigated ... and found to be accurate”* and which *“have not been notified or brought to the attention of the Department during the course of the investigation and which it has not had an opportunity to examine or to comment upon”*.

The Ombudsman's intention in reproducing this (mostly) historical material is to illustrate, often in their own words, the frustration and confusion felt by many people in seeking long-stay care for a family member. All of these cases were notified, in the normal way, to the relevant health board or to the HSE at the time. While these cases have not been investigated, in the sense of a formal process resulting in findings and recommendations, all of them have been examined within the Ombudsman's Office. In any event, it is unrealistic to seek to engage now on the merits of the individual cases. For this reason, the Ombudsman did not expect, or seek, a response from the HSE at this stage. In relation to the Department's concerns, the complaints

were made against the health boards (HSE) and were never cases of which the Department should have been notified.

(6) This complainant's mother is now availing of the NHSS and the complainant does not now have to subsidise her mother's nursing home costs.

5. THE LAW PROVIDES...

5. The Law Provides...

Confusion and uncertainty have been the hallmarks of the public health service's involvement in providing long-stay care for older people. This confusion and uncertainty is not primarily a reflection of the state of the law in this area; rather, it stems from the fact that for almost 40 years now much of what happens in practice, on the part of the former health boards and now the HSE, is at odds with what the law actually provides. Indeed, this present report is prompted almost entirely by the fact that, while the law appears to require the State to provide nursing home care for the elderly, the State has been acting as if this were not the case. The State agencies concerned have shown a remarkable capacity to impose a convoluted interpretation on legal provisions which, in fact, are much more likely to mean just what they say - no more and no less. It is apparent that the State agencies have opted for the convoluted interpretation over the simple interpretation on the grounds that the simple approach is the more expensive one.

"It is a remarkable feature of the health service in Ireland that such vast sums of money are expended on a system, the statutory basis for which is so confused and haphazard and where practice seems so dislocated from theory."

Senior Counsel advice to the South Eastern Health Board in 2002

This chapter sets out the relevant legal provisions and considers their implications for service provision. The chapter sets out also the interpretation of these provisions favoured apparently by the Department and by the HSE and analyses this interpretation by reference, amongst other things, to court judgments dealing with similar provisions of the Health Act 1970.

The legislation of most relevance is the Health Act 1970; this has been amended on numerous occasions since its enactment and unfortunately there is no consolidated version available. In late October 2009 the key provisions of the NHSS Act 2009 were commenced and these further amend the 1970 Act. However the full significance of the NHSS Act changes, dealt with in Chapter 7, remain to be seen. In any event, during the greater part of the period under review in this investigation, the NHSS Act changes did not apply.

The Department, itself responsible for the drafting of the legislation, promotes the view that the Health Act 1970 is so unclear as to result in significant doubt as to what in fact is required to be provided in law. ⁽¹⁾ The analysis set out below suggests that, at least insofar as in-patient services are concerned, there is no doubt as to what the Health Act 1970 provides.

The Health Act 1970 establishes two levels of eligibility for health services: full eligibility (the "medical card") and limited eligibility. Those with

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

full eligibility are covered for a wider range of services than are those with limited eligibility. In brief, full eligibility amongst other things covers a person for general practitioner services, prescribed drugs and for hospital in-patient and out-patient services; all of which are to be provided by the health board (now the HSE) free of charge. [From 1 October 2010 a 50c charge will apply in respect of each prescription item dispensed to medical card holders. The total charge per family is capped at €10 per month.] In the case of those with limited eligibility, they are not covered for GP services nor for prescribed drugs (though they may avail of a refund scheme where spending on prescribed drugs exceeds a set limit); they are entitled to be provided with hospital in-patient and out-patient services but these hospital services are not free of charge.⁽²⁾

Full eligibility, as defined at section 45 of the Health Act 1970, covers persons who are ordinarily resident in the State and who, in the opinion of the health board (HSE), following an assessment of means, are *"unable without undue hardship to arrange general practitioner, medical and surgical services for themselves and their dependants"*. In 2001 full eligibility was extended to all aged 70 years and over irrespective of means. This necessarily increased significantly the number of people covered by the medical card. However, this automatic entitlement to a medical card was repealed with effect from 2009; in its place, and following considerable public controversy, a specific statutory income test was put in place for those aged 70 years and older. At present roughly 33% of the public have medical card cover.

In the context of this investigation, the key category of service at issue is in-patient services. Prior to the Health (Amendment) Act 2005, medical card holders had the right to in-patient services free of charges. Since 2005, medical card holders are liable for a charge

after 30 days of in-patient services. Those with limited eligibility (in effect, all who have not got a medical card) have always been liable for in-patient charges after 30 days.

Section 51 of the Health Act 1970 defines in-patient services as *"institutional services provided for persons while maintained in a hospital, convalescent home or home for persons suffering from physical or mental disability or in accommodation ancillary thereto"*.

It is well established that the kind of care typically provided in a nursing home falls within the definition of "in-patient services". This much was clarified in the 1976 judgment of the Supreme Court in *Re Maud McInerney [A Ward of Court]*. The applicant was an elderly woman, a Ward of Court, being cared for by the Eastern Health Board in St. Brigid's Home, Crooksling, Co. Dublin. Ms. McInerney was being charged for her care by the Health Board on the basis that the service being provided was institutional assistance. The Supreme Court held, however, that the service being provided to Ms. McInerney constituted in-patient services (rather than institutional assistance) and, as she had a medical card, the health board was not legally entitled to charge her. The Court noted that Ms. McInerney was receiving *"the nursing care requisite for a patient of her age and state of health in a geriatric institution"* and that the *"regimen of treatment ... involves nursing ... supervision, activation and other para-medical services, which are given in an institutional setting. In other words, what she is getting is 'in-patient services', which she requires because she is a geriatric patient."* ⁽³⁾

It is of interest that in this key case, which clarified the nature of the service being provided in nursing homes, court action to protect and vindicate the rights of the elderly person concerned was initiated by the Office of Wards of Court rather than by the elderly person herself or by her family. This suggests a reluctance or perhaps an inability on the part of ordinary people to test their legal right to publicly provided nursing home care - a view shared by the Travers Report (see opposite).

Following on from the *McInerney* judgment, one might have expected that henceforth medical card holders receiving public nursing home care would not be charged; or, in the alternative, that the law would be changed to authorise charging in the case of medical card holders receiving nursing home care. In fact, for the next 28 years health boards continued with the practice of charging for nursing home care in the case of medical card holders. This was an illegal practice which, when it was highlighted in late 2004, resulted in a major controversy and led ultimately to a statutory scheme (the Health Repayment Scheme) to refund those who had been charged illegally. ⁽⁴⁾ The extent of this illegal charging was added to, inevitably, by the fact that the medical card had been extended in 2001 to all aged 70 years and over irrespective of means. Shortly afterwards, the Health Act 1970 was amended to allow for the charging of medical card holders after 30 days of in-patient services. In effect, this means that all long-stay patients, with or without a medical card, can now be charged for the service provided.

However, what is at issue primarily in this investigation is not whether health boards (HSE) were entitled to charge for nursing home care for the elderly; rather, the issue primarily is whether the health boards (HSE) were/are obliged to provide nursing home care for the elderly.

“Indeed, it may be considered that absence of challenge to any such unlawful practices arose, to a large extent, because of the physical and or mental vulnerability of the people concerned.”

Travers Report, para. 3.43

Legal obligation to provide?

On the face of it, the law places a clear obligation on the HSE to provide in-patient services for all who are ordinarily resident in the State. Section 52(1) of the Health Act 1970 says, in plain and unambiguous terms, that a **“health board [HSE] shall make available in-patient services for persons with full eligibility and persons with limited eligibility”**. It is relevant to note the mandatory and unqualified nature of this provision.

Leaving to one side the relevance of the NHSS Act 2009, it has been clear since the *McInerney* judgment of 1976 that nursing home care is a service comprised within the wider category of in-patient services and, accordingly, section 52(1) of the Health Act 1970 applies. On the face of it, therefore, health boards and now the HSE are obliged to provide nursing home care for all those ordinarily resident in the State who need such care. The Ombudsman Office’s long-held position on this was set out in considerable detail in a presentation made by the then Ombudsman, Kevin Murphy, to the Oireachtas Joint Committee on Health and Children on 21 June 2001:

“There is one issue raised in the [Ombudsman’s Nursing Home Subventions] report, in relation to legal entitlement under the Health Acts, which is still outstanding and the subject of ongoing complaint to me. So far this year, complaints about health matters have increased by over 100% relative to the same period last year. These complaints in the main relate to the question of whether

“Under the Health Acts (in particular, Section 52 of the Health Act, 1970) health boards are obliged to make in-patient services available to everyone who lives in Ireland. [...] the Department of Health and Children take the view that the legislation does not confer a legally enforceable right on any person. This argument was first advanced in response to the Ombudsman’s report and has since been restated in the 2001 Health Strategy. The argument is that the Health Acts distinguish between eligibility for services and entitlement to them and that being eligible does not mean that a person has an entitlement. The Ombudsman dismissed this argument....The writer strongly agrees with the Ombudsman. In practice, it seems to be accepted by the Department and the health boards that people have an entitlement to avail of in-patient services in public hospitals but not in long stay care places”.

Older People in Long-Stay Care, Human Rights Commission, (November 2002)

people with medical cards are entitled to the provision of long stay care.

The legal position in relation to hospital in-patient services is relatively straightforward. Everybody resident in the State has an entitlement to be provided with in-patient services, where necessary, by the relevant health board. The service may be provided directly by the health board in one of its own hospitals, or in another publicly funded hospital (e.g. the so-called “voluntary” hospitals), or by way of a contracting out arrangement between the health board and a private institution. [...] Where the patient is covered by a medical card then the service is free of charge.

The definition of “in-patient services” as provided at Section 51 of the Health Act, 1970, means institutional services provided for people while maintained in a hospital,

convalescent home or home for persons suffering from mental or physical disability or in accommodation ancillary thereto. As well as covering acute hospital stays, the term self-evidently includes wider categories of service such as the long-stay care of elderly or disabled people. [...] I consider that any elderly person who needs long-stay nursing home type care - which typically includes nursing care, supervision, assistance with daily activities such as feeding and dressing and which may also include services such as physiotherapy or occupational therapy - is entitled to have this service provided by the relevant health board as an aspect of in-patient services.

*The Department of Health and Children disputes the view that the Health Acts confer a legally enforceable entitlement to hospital in-patient services. It is the view of the Department that the law is unclear as to whether people have a statutory right to be provided with nursing home type care by a health board. [...] **I do not accept that there is any doubt as to the obligation on health boards to provide in-patient services for eligible people. This is clearly established by Section 52(1) of the Health Act 1970.” (emphasis added)***

The Department has set out its position on this on many occasions since 2000; for example, it did so in a January 2004 Background Paper (published as an appendix to the Travers Report), entitled “Long Stay Charges in Health Board Institutions”, prepared for intended submission to the Attorney General in the context of a request for legal advice:

“The Department has long held the view that the Health Act 1970 (as amended) distinguishes between ‘eligibility’ and ‘entitlement’ (although the two terms are often used interchangeably). To be eligible

means that a person qualifies to avail of services, either without charge (full eligibility) or subject to prescribed charges (limited eligibility). Section 52 of the 1970 Act requires health boards to 'make available' in-patient services for persons with full eligibility and persons with limited eligibility; however the manner and extent to which in-patient services are to be made available and the nature and extent of the in-patient services to be provided are not specified. The nature of the obligation imposed on health boards to make available in-patient services is not such as to confer an entitlement on an individual insofar as this may be taken to mean a legally enforceable right capable of being enforced by mandatory order."

The Department makes much of the fact that it has "long held the view" set out above. While this Office has not been in a position to test the proposition with the Department - as it has withheld co-operation in the conduct of this investigation - it does seem to be the case that this view dates back no further than the year 2000 and was developed in the context of the Department responding to a draft of the Ombudsman's report *Nursing Home Subventions*. Certainly, in a number of detailed discussions which the Ombudsman's Office had with senior Departmental officials dating back to the early 1990s, there seemed then to be an acceptance of the view that the health boards were statutorily required to provide in-patient services **(5)**. As late as 1999, in dealing with this specific question in the Dáil, the then Minister appeared to accept that health boards had a "statutory obligation to provide (in-patient services) subject to charges where relevant" to medical card holders (to which category the question related); however, according to the Minister, this obligation was qualified by the need to have regard to the availability of resources and that priorities would need to be set and that there could be "waiting periods for services". Interestingly, the Minister

in 1999 made no mention of a distinction between "eligibility" and "entitlement" nor of the Department's long-held view that the Health Act 1970 does not confer an entitlement to services. ⁽⁶⁾

It seems clear that there is no substance to the argument that the right to in-patient services is qualified by a requirement to have regard to the availability of resources. This was the line put forward by the Minister for Health and Children, in the instance cited immediately above, when he referred to section 2 of the Health (Amendment) (No. 3) Act 1996. This matter was dealt with in the High Court in 2002 in a case (*O'Brien v South Western Area Health Board*) which raised the question of whether the right of an expectant mother, under section 62 of the Health Act 1970, to be provided by her health board with maternity and midwifery services included the right to services for a home delivery. In the course of the case, the High Court had to adjudicate on whether or not cost implications, or the availability of resources, could be invoked by the health board as a qualification on its obligations under section 62. In the event, Ó Caoimh J. found that such a qualification does not apply, stating:

"... I accept, that if a clear statutory obligation exists, economic considerations cannot override the requirement of the section and I am satisfied that s.2 of the Health (Amendment) (No. 3) Act 1996 cannot be construed as overriding any clear statutory obligation to provide a specific service." ⁽⁷⁾

SUGGESTED ANALYSIS OF PROVISIONS OF HEALTH ACT 1970 ...

It is possible to construe the health service provisions of the Health Act 1970 in a relatively straightforward fashion. The suggested construction of these provisions (below), while not purporting to be definitive, supports the view that the rather tortuous construction proposed by the Department is neither necessary nor plausible. In the interests of clarity, this analysis is based on the Act as enacted in 1970, prior to subsequent amendments (which provided for charges in some instances where, originally, no charge was allowed). This is done on the basis that subsequent amendments have not altered the fundamental scheme of the Act in general terms.

Part IV of the 1970 Act, dealing with Health Services, is the Part of immediate relevance to the public; it sets out the range of services to be provided and identifies to whom, and on what terms, the services will be provided. Part IV contains six chapters (under the headings *Eligibility, Hospital In-Patient and Out-Patient Services, General Medical Services, Services for Mothers and Children, Other Services* and *Miscellaneous Provisions Regarding Services*). The overall scheme of Part IV is that Chapter I (Eligibility) identifies, in general terms, the categories of person to which services will be provided; the remaining chapters, for the most part, identify the specific services to be provided, to which categories and on what terms (free of charge or potentially subject to a charge). There is also a small number of services to be provided universally and without charge.

Chapter I of Part IV

identifies two separate categories of person as falling within the ambit of the 1970 Act; those with full eligibility (medical card) and those with limited eligibility. With the exception of a small number of services to be provided universally, services under Part IV are directed at these two categories. When enacted initially, and for many years afterwards, there was a third category of person (with neither full nor limited eligibility) which for the most part remained outside the ambit of the Act. Health boards were allowed to provide certain services to this excluded category but, if so, this was at the discretion of the particular board and was subject to a charge. ⁽⁶⁾ This is an important point which illustrates that, whereas the health boards generally had no obligations to this excluded category, they did have obligations to the other two categories.

Having identified the categories of person within its ambit, Part IV of the Act proceeds on a chapter by chapter basis to deal with specific services (the descriptions below are in summary form only):

Chapter II

deals with **in-patient and out-patient services**. It provides that health boards “*shall make available in-patient services for persons with full eligibility and persons with limited eligibility*” (section 52); it provides that charges for in-patient services may be prescribed by Ministerial regulation but will not apply in the case of persons with full eligibility (section 53); provides that a health board may provide in-patient services to a person with neither full nor limited eligibility but this will be subject to a mandatory charge (section 55). In the case of out-patient services, it defines the term and provides that health boards “*shall make*

available out-patient services without charge for persons with full eligibility and persons with limited eligibility”.

Chapter III

deals with **general medical services**. It provides that a health board *“shall make available without charge a general practitioner medical and surgical service for persons with full eligibility”* (section 58); that a health board *“shall make arrangements for the supply without charge of drugs, medicines and medical and surgical appliances to persons with full eligibility”* and for a subsidy scheme towards these same costs in the case of those with limited eligibility (section 59); in relation to home nursing, it provides that *“a health board shall, in relation to persons with full eligibility and such other categories of person and for such purposes as may be specified by the Minister, provide without charge a nursing service ...”* (section 60); it provides that a health board may provide a home help service to *“assist in the maintenance at home”* of a sick or infirm person or of a woman receiving maternity services or of a person who, but for such assistance, would not be able to live at home and such service may be with or without charge at the discretion of the health board (section 61).

Chapter IV

deals with **services for mothers and children**. It provides that a health board *“shall make available without charge”* medical and midwifery services for mothers whether with full or limited eligibility (Section 62); that a health board *“shall make available without charge”* medical care for infants whose mothers have availed of services under section 62, that is, those with full or limited eligibility (section 63); that a health board *“shall make available without charge”* a

health examination and treatment service for children under six years of age and for children attending a national school and these services are not confined to children whose parents have either full or limited eligibility (section 66).

Chapter V

deals with **other services**. It provides that a *“health board shall make dental, ophthalmic and aural treatment and dental, optical and aural appliances available for persons with full eligibility and persons with limited eligibility”*; charges for these services may be prescribed by Ministerial regulation but will not apply in the case of persons with full eligibility (section 67); that a health board *“shall make available a service for the training of disabled persons for employment”* and this applies irrespective of eligibility status (section 68); that *“a health board shall provide for the payment of maintenance allowances to disabled persons over sixteen years”* (section 69).

Chapter VI

deals with **miscellaneous provisions regarding services**. Nothing in Chapter VI has particular relevance to this present analysis.

From this summary of Part IV of the Health Act 1970 it is clear that the Act provides for:

- certain specified services which must be provided and for other services which may be provided;
- categories of persons to whom specified services must be provided and, in some instances, a category of persons to whom a specified service may be provided;
- the imposition of mandatory charges in the case of specified services provided to specified categories of persons (the home

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

help service is an exception in that the imposition of a charge is discretionary);

- the full range of specified services being made available free of charge to medical card holders (with the exception of the home help service where the provision of the service is not mandatory and where the imposition of charges is at the discretion of the health board).

In the case of the key services, the language used in Part IV of the Act is that a health board “shall make [the service] available” to those with full eligibility and, in some instances (including in-patient services), to those with limited eligibility. It is of particular relevance to note that, in all instances of significance, the formula used in Part IV requires specific action by health boards; the formula of words is not qualified by being made subject to any conditions. Very importantly, in Chapters II - V of Part IV the term “eligibility” is used solely as an identifier of those to whom services shall or may be made available. Thus, when section 52 provides that a health board “*shall make available in-patient services for persons with full eligibility and persons with limited eligibility*”, it is very clear that the reference to “eligibility” is intended to identify those categories to which the service shall be made available. In the context of Chapters II - V of Part IV of the Health Act 1970 there is no issue of possible confusion between the terms “eligibility” and “entitlement”.

“Eligibility” versus “Entitlement”

Nevertheless, the Department contends that these two terms appear to be used interchangeably in the Health Act 1970 and that this gives rise to confusion and uncertainty. A close reading of the Act does not support this contention. In a number of the sections of Part IV of the Act the terms “entitled” or “entitlement” are used but never in a fashion which suggests that it is intended to mean anything other than its plain meaning. Some examples are set out immediately below.

Section 50 provides for a situation in which a person obtains a service and it is subsequently ascertained that he was not “**entitled** to the service”. ⁽⁹⁾ Section 54, which was repealed in 1990, provided for arrangements for payment of a grant where a person “*entitled to avail himself of in-patient services under section 52*” opts instead for private treatment in an approved institution. ⁽¹⁰⁾ Section 55 provides that a health board may make in-patient services available “*for persons who do not establish **entitlement** to such services under section 52*”. ⁽¹¹⁾ And section 63 provides for services for infants “whose mothers are **entitled** to avail themselves of services under section 62”. ⁽¹²⁾

There seems not to be any confusion here. Where the Act provides that a health board shall make a particular service available to an identified category of person then any member of that category is conferred with an entitlement to the particular service. The term “eligibility” is used only in the context of identifying those categories to whom services shall or may be provided; it is never used in the context of defining the extent to which services must be provided. It might indeed have been more appropriate for the legislature to have chosen entirely neutral terminology in delineating the various categories of health entitlement - for example, Category I and Category II - but it did not.

On this approach, which the Ombudsman favours, there is a statutory right for persons in both eligibility categories to have in-patient services provided to them by the relevant health board (HSE). How this right should be enforced by the courts is a separate matter; but that it is capable of being enforced seems correct. Indeed, as discussed below, the courts have adjudicated upon other elements of the overall package of health services provided in Part IV of the 1970 Act.

The logic of the Department's position is that failure, in a particular case or cases, to **“make available in-patient services for persons with full eligibility and persons with limited eligibility”** does not necessarily involve a breach of a statutory duty. One can accept that the 1970 Act does not provide a very specific definition of what is encompassed by the category “in-patient services” and there might be room for genuine debate as to the extent of what the Act envisages - though the 1976 *McInerney* judgment goes a considerable distance towards defining “in-patient services” in so far as it applies in nursing home situations. But it is very difficult to see that the plain wording of section 52 of the 1970 Act can be construed as allowing for a situation in which no service is provided to a person who, for example, is assessed as being in need of long-stay nursing home care. In these situations, faced by many of the Ombudsman's complainants over the past 25 years, placing a person on a waiting list for services (and the use of waiting lists in this area seems to have been haphazard) cannot be seen as a satisfactory solution.

The Department's position, that there is confusion between “eligibility” and “entitlement”, is a generalised one rather than one arising solely in relation to in-patient services. Logically, therefore, the lack of clarity which the Department says exists, as well as the opinion that there is not an enforceable right to services, must apply across the full range of services which, under the 1970 Act, the health boards (HSE) “shall make available”. On this basis, the Department should take the view that the HSE has no enforceable obligation to provide in-patient services to a medical card holder (or, indeed, to any other person ordinarily resident in the State) in need of acute hospital treatment. Equally, if the Department is correct, a road traffic accident victim arriving to the Emergency Department of a HSE hospital has no specific legal entitlement to be treated;

nor has a woman about to give birth any enforceable legal right to maternity services. Nor, on this basis, can the HSE be required to arrange GP services for medical card holders nor required to operate a drugs refund scheme for those without medical cards. This can hardly be the case; and the Ombudsman is not aware that the Department has ever claimed this to be the case.

What we learn from Court Judgments ...

There are several hundred legal actions outstanding in which elderly people who have had to avail of private nursing home care, in the absence of public nursing home places, are seeking to be compensated by the State for the costs incurred in private care (see Chapter 8). In effect, these people are seeking vindication by the High Court of their right to be provided by their health board (HSE) with in-patient services. In the course of this investigation, the Ombudsman sought details from the Department and from the HSE regarding this litigation; both bodies refused to co-operate even to the extent of refusing statistics on the number of individual actions involved. From other sources we have been able to get a picture of the extent of this litigation and of the specific claims being made. ⁽¹³⁾ At the time of writing, we understand none of these cases has gone to hearing and judgment in the High Court. Neither, it would appear, has the High Court otherwise dealt with the specific question of whether there is an enforceable right to be provided with in-patient services under section 52 of the Health Act 1970. However, there is considerable guidance available from judgments of the Superior Courts dealing with section 52 as well as judgments on other similar provisions of Part IV of the Health Act 1970.

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Statutory Interpretation

The Department's contention is that section 52 of the Health Act 1970 is not to be understood as conferring a right to in-patient services on any individual person nor as placing an obligation on the HSE to provide in-patient services to any individual person. This contention is plausible only where one accepts that the plain language of section 52 ("*... shall make available in-patient services for persons with full eligibility and persons with limited eligibility*") should be set aside in favour of an interpretation based on a different, and less usual, understanding of the meaning of the words of the section. As the Ombudsman understands it, in the case of a statute which is directed to the public at large (as is the case with the Health Act 1970) a word or expression should be given its ordinary or colloquial meaning. And in fact the Supreme Court, in a recent judgment, expressly applied this approach to the interpretation of the Health Act 1970.

The issue raised in *Tierney & Ors v North Eastern Health Board* ⁽¹⁴⁾ concerned the construction of section 38 of the Health Act 1970 and whether the then North Eastern Health Board had the power to discontinue maternity services at Monaghan General Hospital. In the course of her judgment (with which the other two judges concurred) Denham J. distinguished between the duty of a health board to provide certain services and the quite separate question of where such services should be provided. In the course of her judgment, Denham J. observed, with reference to the Health Act 1970:

"Statutes should be construed according to the intent expressed in the legislation. The words of a statute declare best the intent of an Act. The language of the relevant sections of the Act of 1970 is clear. Consequently those words should be given their ordinary meaning. The Court is bound to give effect to the clear meaning of the statute."

Section 52

The judgment of the Supreme Court in *Tierney* seems also to have a direct relevance to the correct interpretation of section 52 of the Health Act 1970. In the course of her judgment in that case, Denham J. sets out to "consider and construe the relevant statutory provisions". Amongst the provisions which she identifies as "relevant" is section 52 which she deals with in the following terms:

"A fundamental duty of the respondent [health board], as stated in s.52, is to provide inpatient services for persons of full eligibility and persons with limited eligibility. Section 52 clearly provides that a health board shall make available inpatient services for persons with full eligibility and with limited eligibility."

Denham J. identifies section 62 of the 1970 Act, dealing with maternity services, as another relevant provision requiring to be considered and construed. Her conclusions in relation to that provision are as follows:

"This case relates to maternity services. Section 62 expressly states that a health board, such as the respondent, shall make available without charge medical, surgical and midwifery services for the health, in respect of motherhood, of women who are persons with full eligibility or persons with limited eligibility."

Her overall conclusion is that, while health boards (and now the HSE) have a duty to provide certain services, including in-patient services and maternity services, there is flexibility within the legislation as to where these services should be provided:

"The Act of 1970 gives a general duty to the respondent to provide services, such as maternity services. This obligation is stated in sections of the Act of 1970 including s.62. However, the statute does not mandate where the services should be provided. The respondent may meet its obligation by providing the services anywhere in its region."

The interpretation of section 52 was touched on also in the Supreme Court judgment in *Re Article 26 and The Health (Amendment) (No. 2) Bill 2004*. The Health (Amendment) (No. 2) Bill 2004 purported to provide a retrospective legal basis for the charging of medical card holders, over a period of almost thirty years, for the provision of in-patient services in public nursing homes; it also sought to provide a legal basis for such charges in the future. In its judgment the Supreme Court found that the retrospective provisions of the Bill were unconstitutional. In reaching this conclusion, the Supreme Court reflected on the nature of the then existing provisions of the Health Act 1970 dealing with in-patient services. It appears the Court took it as self-evident that section 52 requires or obliges health boards (HSE) to provide in-patient services.

“The sum total of these provisions is that, by the legislation of 1970 ... the Oireachtas required and has continued to require Health Boards, at all times prior to the passing of the Bill, to make in-patient services available without charge to all persons ‘suffering from physical or mental disability’. While the individual circumstances of patients will vary enormously in terms of age and physical and mental capacity, it is obvious that, by enacting the Act of 1970, the Oireachtas was concerned to ensure the provision of humane care for a category of persons who are in all or almost all cases those members of our society who, by reason of age, or of physical or mental infirmity, are unable to live independently. They are people who need care. Even without the benefit of statistical or other evidence, the Court can say that the great majority of these persons are likely to be advanced in years. Many will be sufferers from mental disability. While some will have the support of family and friends, many will be alone and without social or family support.” (our emphasis) ⁽¹⁵⁾

Related Sections

Issues of entitlement to specific services under Part IV of the Health Act 1970, other than in-patient services, have also been considered by the Courts. In particular, section 56 (out-patient services), section 60 (home nursing) and section 62 (medical and midwifery care for mothers) have been the subject of comprehensive judgments in the Superior Courts. In each of these instances, the structure of the particular section and the language used are very similar to the structure and language of section 52.

Sections 56 and 60 of the Health Act 1970 were considered by the High Court and subsequently by the Supreme Court in *C.K. v Northern Area Health Board*. In his High Court judgment ⁽¹⁶⁾ Finnegan P. noted the mandatory nature of both sections 56 and 60 and held, having regard to the actual level of service provided under these two sections that, on both counts, the Health Board was “in breach of its statutory duty to P.K.” (on whose behalf the action was initiated by his sister). An issue had also been raised in relation to entitlement under section 61, dealing with the home help service. In that instance Finnegan P. noted that “section 61 is regulated by the word ‘may’ rather than the word ‘shall’ “ and he held “there is no statutory right to such services” as it was a matter of policy for the Health Board and the Minister as to whether home help services should be provided and, if so, to what extent. An interesting aside in this judgment is that the President of the High Court commented that it was striking that P. K. could only be provided for by way of out-patient services as no institutional provision was available in any real sense as required by section 52 of the Act.

The Health Board appealed this judgment to the Supreme Court. In so doing, one of its grounds of appeal was expressed as follows: *“the provisions of section 56 of the Health Act 1970, as amended, do not give rise to*

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

individually enforceable statutory rights in the applicant". A second ground of appeal made a similar claim in relation to section 60 and the home nursing service. Clearly, the Health Board understood the judgment of the High Court as having established explicitly that the right to out-patient services and the right to home nursing are individually enforceable statutory rights.

The Health Board was successful in its appeal to the Supreme Court but on the very specific grounds that the High Court was mistaken in the view (a) that out-patient services included the provision of services in the patient's home and (b) that the home nursing service required the provision of "a long term virtually full-time (or even extensive part-time) nursing service for disabled persons in their own homes". Significantly, the Supreme Court gave no ruling on the decision in principle of the High Court that the Health Board had failed to satisfy the applicant's entitlement under sections 56 and 60 of the Health Act 1970. It is particularly significant that the Supreme Court gave no ruling on the appeal claim that "*the provisions of section 56 [and section 60] of the Health Act 1970, as amended, do not give rise to individually enforceable statutory rights in the applicant*". Thus the High Court's recognition that, in principle, the Health Act 1970 confers statutory entitlements to out-patient services and home nursing services remains undisturbed following the appeal to the Supreme Court.

Likewise the issue of entitlement to services under section 62 of the Health Act 1970, which provides for medical and midwifery care for mothers (again in a structure and language virtually identical to section 52), was considered by the Courts in *Spruyt & Anor v Southern Health Board* ⁽¹⁷⁾ and latterly, in *O'Brien v South Western Area Health Board*. In both cases the point at issue concerned the right of a pregnant woman to be provided by her health board with a domiciliary midwifery, or home birth,

service. In *Spruyt*, section 62 was given its plain and unambiguous meaning by the Supreme Court. In so doing, the Court held that there was a statutory obligation under section 62 to provide midwifery services through a general practitioner or midwife. The Court also held that a health board's obligation under that provision could not be satisfied by an offer to indemnify a person entitled to such services against the cost of making her own arrangements with a private practitioner; such an offer is not a purported discharge of its obligation under the section but rather an ex gratia arrangement. In *O'Brien*, the High Court recognised this obligation to provide midwifery services as a statutory requirement. ⁽¹⁸⁾ Finally, it is clear from the very recent Supreme Court judgment in *Tierney*, as cited above, that health boards (and now the HSE) have a duty to provide maternity services.

What is significant about these judgments, dealing with services under sections 56, 60 and 62 of the Health Act 1970, is that the Courts have found quite clearly that these provisions place statutory obligations on health boards (and now the HSE) and confer enforceable rights on relevant individuals identified as persons to whom services shall be made available. There is no reason to believe that, in the case of section 52 (in-patient services), the Courts would take any view other than that it also places statutory obligations on the health boards (HSE) and confers enforceable rights on relevant individuals.

As for the strength of the Department's assertion that section 52 does not confer enforceable rights, the present Minister has, on at least one occasion, taken a rather neutral stance on the matter. In the course of a Dáil Debate on 1 June 2006, the Minister (replying to questions posed by Dr. Liam Twomey, T.D.) commented:

“The issue of whether everyone over 70 is entitled to a bed funded by the State and, if a bed in a public facility is not available, whether the State must fund a bed in a private nursing home, is being tested in the courts. As we know from the 29-year-old issue concerning charges, no legislation we introduced could be retrospective. I do not know how this will be determined.”

Dental Services - A related Issue...

A controversy has arisen in recent months in the area of dental services following a decision by the HSE to curtail very significantly the level of dental treatment to be made available to medical card holders through private dental practitioners. ⁽¹⁹⁾ This is relevant in the present context in that the legal obligation on the HSE to provide dental services is very similar to that governing the provision of in-patient services. Section 67 of the Health Act 1970 provides:

“67.—(1) A health board shall make dental, ophthalmic and aural treatment and dental, optical and aural appliances available for persons with full eligibility and persons with limited eligibility.”

This provision was amended by regulation in 1972 with the deletion of the requirement to make services available to those with limited eligibility; it remains unamended insofar as those with medical cards are concerned. There is no basis for charging for the service to be provided to medical card holders.

While the 1970 Act does not define the extent of the dental service required to be provided under section 67, it is clear that, at a minimum, it is intended to include basic dental treatment and emergency treatment to relieve pain. The comments of Finnegan P. (see page 62), in relation to the extent of service to be provided under the heading of “out-patient services”,

appear applicable: decisions as to the level of service to be provided must meet the test of reasonableness and be neither capricious nor arbitrary.

It has long been acknowledged that the health boards never employed sufficient numbers of dentists and have failed over decades to meet their statutory obligation in the dental area. ⁽²⁰⁾ In 1994, the health boards sought to improve their level of compliance with the section 67 requirement by involving private dentists in the treatment of adult medical card holders. This is under a scheme known as the Dental Treatment Services Scheme (DTSS). It is reasonable to assume that the establishment of the DTSS was with a view to meeting the statutory entitlements, under section 67, of medical card holders.

In April 2010 the HSE cut back very considerably on the range of treatments to be provided under the DTSS to medical card holders. Under the new arrangements, the DTSS is now directed at “emergency dental care ... with a focus on relief of pain and sepsis”. In effect it appears that, in any twelve month period, treatment under the DTSS is now limited to one oral examination, two emergency fillings and emergency extractions only with “additional care ... considered in exceptional or high risk cases”. ⁽²¹⁾ In a context in which the HSE does not employ sufficient dentists of its own, it is inevitable that this curtailment of the DTSS will result in medical card patients not receiving the level of service to which they are entitled in law. Indeed even under the DTSS hitherto, it is probable that medical card holders were not receiving the level of service to which they are entitled in law. Within the HSE itself, there appears to be an acceptance that the DTSS restrictions mean that medical card holders will suffer a “diminution of their entitlements”. ⁽²²⁾

The dental services issue is relevant here because it shows that the practice of the

“The decision as to the services which ought to be provided [under out-patient services] in any particular case is an administrative one. However, the decision as to the services to be provided must not be capricious or arbitrary. Further, the decision as to the appropriate out-patient services must not be such that it could not reasonably have been arrived at within the sense of the term ‘reasonable’ as defined in The State (Keegan) V Stardust Victims Compensation Tribunal ...”.

Finnegan P. in *C.K. v Northern Area Health Board* [2002] 2 I.R. 545

Department and of the HSE in the case of long-stay care for the elderly is one instance of a wider pattern of behaviour. This involves a disregard for what the law actually requires and a failure (over 40 years) to have the law amended so that practice and the law are in harmony. This behaviour, quite clearly, is bad for those who are being deprived of services to which they have a statutory right but, on a much more fundamental level, it is bad for our system of government.

In the very difficult financial circumstances now facing this State, it may be inevitable that

“The Treatment Benefit Scheme is a scheme run by the Department of Social and Family Affairs (DSFA) that provides dental, optical and aural services to qualified people. [...] Medical card holders are legally entitled to more extensive dental, ophthalmic and aural services from the Health Service Executive (HSE) but, in practice, the availability of these services varies from area to area.”

Department of Social Protection’s information leaflet on Dental Benefits
<http://www.welfare.ie/EN/Schemes/DentalOpticalAndHearingBenefits/Pages/Dental.aspx>

funding across a range of public services will be cut. It may be necessary to curtail or suspend entirely services which there is an existing statutory obligation to provide. If, as the present Minister for Health and Children avers, “[w]e are a society ruled by law” (23), any such curtailment or suspension of statutory services must be brought about in a legally correct fashion. But in circumstances in which some of the legal requirements of the Health Act 1970 have been disregarded for decades, it is no great surprise that (in the case of dental services, for example) further restrictions on statutory services are implemented without any apparent regard for the law. Action of this kind inevitably brings the law into disrepute.

Postscript - Department’s response to this Chapter

For a wide range of reasons, the Department rejects the legal analysis set out in this chapter. It is not feasible to deal in detail with all of the arguments advanced by the Department. However, there is one key point of opposition which the Ombudsman wishes to address. This point is summarised in the following extract from the Department’s response to a draft of this chapter:

“One of the implications of the views of the Ombudsman ... is that section 52 of the Health Act, 1970 imposed an obligation on Government since 1970 to provide in-patient services to the population with full and limited eligibility, on demand (no waiting lists) and with no cap on the resources available. Taken to its logical conclusion, this would mean that the Oireachtas intended to establish a single-tier health system in respect of all in-patient services (i.e., hospitals, convalescent homes, homes for persons suffering from physical or mental disabilities and accommodation ancillary thereto). The arrangement since then where a large proportion of the population paid for private health insurance

which, in turn, assisted in funding the hospital system for example, would thus have been rendered moot.

Furthermore, the eligible population would have had to be provided with the service on demand and so the system, logistically, would have to have an excess of capacity to ensure this would happen. The contention that there is no cap on the resources allowed for in-patient services would, in effect, mean that such services would become a demand-led service with no ceiling on expenditure.

[...]

To impute that in-patient services were demand-led for the entire population with full and limited eligibility since 1970 would, in effect, have prioritised these services over community-based services. If such were the case, the community-based services would not have developed at all. It would also not have reflected Governments' commitment to the delivery of a more holistic health and personal social services model, with an emphasis on community-based services."

In some respects, this is the "appalling vista" argument: the consequences of accepting the truth of the situation are so overwhelming that it is not sensible to even contemplate that possibility.

The Department argues that acceptance of the Ombudsman's analysis of section 52 of the 1970 Act would involve having a demand-led hospital service, with no waiting lists and no cap on resources. This is a gross overstatement of the consequences of an acceptance of the Ombudsman's analysis. The Ombudsman acknowledges that section 52 of the Health Act 1970 places a very considerable burden on the State in providing for in-patient services. However, this does not amount to a "demand-led" service.

The Department (in the above extracts) refers to the intentions of the Oireachtas and to the commitment of the Government. Ideally, these two categories should be in proper alignment. In fact, much of the difficulty described in this present report arises from the fact that the commitment or policy of the Government has not been given adequate expression in the form of legislation from the Oireachtas. The problem may well be that Government, in the form of the Department, has sought to implement some of its health policies without ensuring that the measures required for such implementation have a clear statutory basis provided by the Oireachtas. If this is the case, then it would appear to exemplify again the extent to which the Oireachtas has been side-lined by the Executive in recent decades.⁽²⁴⁾

In so far as the intentions of the Oireachtas are concerned, these are set out primarily in legislation. The statutory framework for health services is set out in the Health Act 1970 (as amended) and is as outlined earlier in this chapter. It is clear from the 1970 Act that there are certain services which health boards (HSE) must provide and there are other services which they may provide and, indeed, there are certain services which are not anticipated at all in the legislation of 40 years ago.

Of the services which must be provided, there are some which self-evidently have to be provided at a particular point; these include, for example, midwifery and treating accident victims. Some other of the mandatory services need not necessarily be provided "on demand" and it may be acceptable to wait-list people on some kind of priority basis; these might include certain hospital procedures where delay carries no implications for outcome. Furthermore, as the law stands, in many instances there is little elaboration as to the extent of service required to be provided on a mandatory basis; though one might reasonably infer that services should meet some standard which is generally

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

accepted (see comments of Finnegan P. quoted above).

In the case of long-stay care for older people, and leaving aside the current situation following the enactment of the NHSS Act 2009, when the service needs to be provided will depend on an assessment of the particular person. In some cases, it will be reasonable to ask people to wait for a service, in other cases it will be self-evident that the need for care is immediate. The great defect in our arrangements over the period covered by this report is that, in the case of long-stay care, there has not been an adequate supply of long-stay places; nor has there been a rational and coherent system for assessing and prioritising patient placements in a way which meets the requirements of section 52 of the Health Act 1970. The absence of such an approach has meant that, rather than there being a problem of delay, the problem is in very many cases one of failure to provide a service.

The 1970 Act represented a new start for the health service in Ireland and it charted a course based on legal rights and legal obligations. There were, and are, alternatives to this approach. For example, it would be

possible to create a legal framework for health services enabling the provision of services within a flexible model in which service delivery is subject to resource availability and in which eligibility for services is governed by need and is subject to a system of charges. In such a model, government would have the freedom to make sensible corrections including the re-defining of services and the development of new services. However, this is not the model we have in Ireland at present. Nevertheless, some of the developments in health service provision are occurring as if we are operating within this type of flexible model.

Few will disagree with the Government policy that, to the greatest extent possible, older people should be cared for in their own homes for as long as possible and that residential care should be seen as a last resort. The development of community-based services (for example, home care packages) must be seen as a good thing. The provision of such home care packages is probably encompassed by the provisions of section 61 of the Health Act 1970 under which the HSE “*may make arrangements to assist in the maintenance at home ... of a sick or infirm person ...*”. At the same time there are some services which, while long recognised as mainstream services, appear not to be provided for explicitly in the Health Act 1970. Examples of such services include physiotherapy, occupational therapy and chiropody. What has been happening in recent decades is that these other services - where there is no statutory obligation to provide or, in some cases, no statutory basis for their provision - are being developed at a time when statutory obligations are not being met.

A key difficulty with our present approach to the delivery of health services arises from a confusion as to the interaction of policy and legislation. As one commentator has put it:

“The Department is not aware of any country in the world where health and personal social services are provided without some form of prioritisation which reflects the reality of resource limitations. It is not credible to suggest that the Oireachtas, when it enacted the 1970 Health Act, intended and expected all services to be provided immediately once a clinical/social need for them had been established. The reality is that access to health services has always been determined by a combination of clinical and other professional judgments within an overall resource availability envelope. “

Department of Health and Children Submission to Ombudsman (23 August 2010)

“Legislation, in itself, is not a guarantee that policies will be implemented, even if that legislation reflects policy. However, it is a prerequisite for the provision of certain services and, without specific legislation, it is difficult for individuals to establish or vindicate their rights.” (25)

What we appear to have had with the Irish health service in recent decades is an approach which treats the existing legislation with insufficient respect while, at the same time, treating policy positions as if they have the force of law.

The Ombudsman is not suggesting that services such as home care packages or physiotherapy should not be provided; nor is she suggesting that the development of services should be frozen in time to reflect the circumstances prevailing when the primary health law was enacted. What she is suggesting, rather, is that developments should be provided for either (a) within the existing legal framework or (b) that this existing framework be amended in order to validate the proposed developments. Neither of these has happened. The result has been confusion, inconsistency and lack of certainty as to the rights of older people who need long-stay nursing home care. Furthermore, there is the fundamental point that continued disregard for the requirements of the law, even where that disregard may be well-intentioned, undermines the rule of law generally. On a more pragmatic note, the risks associated with neglecting to meet legal entitlements are high; in the longer term, the risk of litigation is real as the litigation currently under way shows. (see Chapter 8).

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Notes

(1) *"The issue of eligibility is something of a patchwork. One is dealing with limited eligibility for certain services and full eligibility for other services. Certain sections of the Health Act 1970 state that some services may be made available while others indicate that they shall be made available. The question is what does the word "shall" mean in that context? Does it provide an entitlement or does it simply grant eligibility? Does access, therefore, depend on resources being made available? The issue of eligibility is extremely complex and the Department was aware of that. It was seeking clarity."*

Mr. Dermot Smyth, Department of Health and Children, speaking at the Joint Committee on Health and Children, (4 May 2005).

(2) The Health Act 1970, as originally enacted, excluded certain categories of people both from full eligibility and limited eligibility; such excluded people, for example, had no right to be provided with hospital services by the health board. Over the years, and particularly in 1979, the number of excluded people dropped following piecemeal legislative changes until the Health (Amendment) Act 1991 provided that "(a)ny person ordinarily resident in the State who is without full eligibility shall, subject to section 52 (3), have limited eligibility ...".

(3) [1976 - 1977] ILRM 229

(4) *The Irish Times* reported on 26 April 2010 that out of 35,000 applications under the Health Repayment Scheme, a total of 21,150 offers of repayment have been made totalling €431 million. According to this report, this equates to average payments of just over €20,000.

(5) *"At the outset, Ms. X [of the Department] accepted that the problems [e.g failure of health boards to provide sufficient public nursing home places] we had identified in November 1991 continue to arise. She acknowledged that it was the case that nursing home services (or long-stay care) did constitute an in-patient service as defined at Section 51 of the Health Act, 1970 and that people did have a statutory right to have this service provided by their Health Board. [...]"*

Ms. X commented that whereas eligibility for services was extended to everybody (in 1979), no change was made in the definition of in-patient services. At the time, she suspects, the Department did not understand the full implications of this change and that it meant that everybody would have an entitlement to in-patient services. The

Department has only slowly come to realise that health boards are now legally obliged to provide long-stay care for the elderly as part of in-patient entitlement."

Interview with Department of Health Officials - Ombudsman Caseworker Note (17 December 1992)

(6) "[...] Under sections 52 (1) and 53 (1) of the Health Act, 1970, there is a statutory obligation to provide, subject to charges where relevant, in-patient services to persons who have full eligibility. [...] However this obligation is qualified by section 2(1) (a) of the Health (Amendment) (No. 3) Act, 1996 which states:

2.–(1) A health board, in performing the functions conferred on it by or under this Act or any other enactment, shall have regard to–

(a) the resources wherever originating, that are available to the board for the purpose of such performance and the need to secure the most beneficial, effective and efficient use of such resources.

In a situation of finite resources it may not be always possible for a health board to meet all demand for its services immediately – hence a need for identification of priorities and assessment procedures which can result in waiting periods for services."

PQ 4798/99 (23 February 1999)

- The reply refers to the provision of in-patient services to medical card holders being subject to a charge; at that point section 53 of the Health Act 1970 specifically limited the option to impose in-patient charges to those with limited eligibility.

(7) *O'Brien v South Western Area Health Board* - Unreported, High Court, (5 September 2002). While this statement appears to have been obiter, and does not constitute a precedent, it is nevertheless a useful indication of judicial thinking on the matter.

Both the Department of Health and Children and the HSE, in their submissions to the Ombudsman, point out that in dealing with this case on appeal the Supreme Court did not deal with "any resource issue". In fact, the Supreme Court opted not to comment on the resource issue on the grounds that it was unnecessary for it to do so as it dismissed the appeal on other grounds.

(8) For example, under section 55 a health board may provide in-patient services to a person not entitled to full or limited eligibility but, in such a case, the service will be subject to a mandatory charge.

(9) **"50.**—*When a person has obtained a service under the Health Acts, 1947 to 1970, and it is ascertained that he was not entitled to the service, the appropriate health board may charge therefor a charge approved of or directed by the Minister."* (our emphasis).

(10) "54.—*A person entitled to avail himself of in-patient services under section 52 or the parent of a child entitled to allow the child to avail himself of such services may, if the person or parent so desires, instead of accepting services made available by the health board, arrange for the like services being provided for the person or the child in any hospital or home approved of by the Minister for the purposes of this section, and where a person or parent so arranges, the health board shall, in accordance with regulations made by the Minister with the consent of the Minister for Finance, make in respect of the services so provided the prescribed payment.*" (our emphasis).

(11) "55.—*A health board may make available in-patient services for persons who do not establish entitlement to such services under section 52 and (in private or semi-private accommodation) for persons who establish such entitlement but do not avail themselves of the services under that section and the board shall charge for any services so provided charges approved of or directed by the Minister.*" (our emphasis).

(12) "63.—*(1) A health board shall make available without charge medical, surgical and nursing services for children up to the age of six weeks whose mothers are entitled to avail themselves of services under section 62.*" (our emphasis).

(13) For example, the *Irish Times* on 3 October 2007 reported that 407 sets of legal proceedings had been filed against the State on the issue of the provision of long-stay care. These included claims of entitlement to free public nursing home care from patients who paid for private care. According to the report, the Department was considering whether to defend or settle cases on an individual basis.

(14) [2010] IESC 43

(15) [2005] 1 IR 105

(16) [2002] 2 IR 545

(17) Unreported, Supreme Court, (14 October 1988)

(18) In *O'Brien v South Western Area Health Board* - Unreported, High Court, (5 September 2002), Ó Caoimh J. accepted, "that if a clear statutory obligation exists, economic considerations cannot override the requirement of the section and I am satisfied that s.2 of the Health (Amendment) (No. 3) Act 1996 cannot be construed as overriding any clear statutory obligation to provide a specific service".

(19) "Cuts will set back services by decades say dentists", *Irish Examiner*, (24 March 2010)

(20) As long ago as 1976 the National Health Council looked at the situation regarding dental services under the Health Act 1970 and reported that "... the existing service was most unsatisfactory and inadequate to deal with the demand from eligible persons. It was estimated that only one-third of the 600,000 eligible children estimated to need attention were examined each year under the scheme. Adults receiving treatment under this scheme number about 50,000 a year out of an estimated 570,000 eligible adults not catered for by other schemes". *Report of the National Health Council, 1976* cited in *The Irish Social Services*, John Curry, Institute of Public Administration, (1980)

(21) Circular 008/10 from Primary Care Reimbursement Service, HSE dated 26 April 2010

(22) Internal HSE memo of 30 April 2010 from four Principal Dental Surgeons. The memo notes that, where medical card patients cannot be treated appropriately under the DTSS, they may well be referred back to the HSE's own dental service which, at present, caters only for "Childrens' and Special Care Dentistry".

(23) Mary Harney T.D., Minister for Health and Children, Dáil Éireann, (16 February 2005)

(24) The Ombudsman has raised this issue on a number of occasions most recently in her speech of 9 March 2010 at the Institute of Public Administration - available at <http://www.ombudsman.gov.ie/en/SpeechesandArticles/Ombudsmansspeeches/Name,11772,en.htm>

(25) Ita Mangan, "Deficiencies of the Law Relating to Care of Older People" in *Older People in Modern Ireland - Essays on Law and Policy*, Eoin O'Dell (ed.) (2006)

6. BROKEN PROMISES...

6. Broken Promises...

People have a right to know where they stand regarding their entitlement to be provided by the State with long-stay care if that becomes necessary in old age. Whatever that level of provision may be, and whatever the terms under which it will be provided, people need to know what they can expect so that they can plan accordingly. Nobody will disagree with this statement. Remarkably for the last 40 years, and despite repeated promises, people in Ireland have not had the comfort of knowing where they stand when a family member is found to need long-stay nursing home care. The centre-piece of this chapter is the story of one family which has had to cope since 1999 with the failure of the State to act on its promise to bring clarity to the area of legal entitlement to long-stay care.

If there is a need for clarity this suggests genuine confusion regarding the law as it stands. As set out in Chapter 5, the Ombudsman does not believe that there have been real grounds for confusion regarding the legal entitlement to be provided with long-stay nursing home care. But if that entitlement is not being honoured, then it is imperative that the law should be changed so that there are no grounds for any party, and particularly the State agencies, to be confused.

“I have often thought ... that the greatest inadequacy in much of our social legislation is not gaps in the laws themselves but a massive gap between what the law provides for citizens by way of assistance and their knowledge of it and capacity to avail of it”

Mr. Justice Thomas A. Finlay in *The Law and Older People*, National Council on Ageing and Older People, (1998)

There are two aspects to this purported uncertainty: firstly (and this is the issue of prime concern in this report), there is the question of whether the State is obliged to provide long-stay care and secondly, if the State is so obliged, is it entitled to charge for such care. The latter question has now been put beyond doubt since July 2005; the former question continues to be raised.

The confusion and lack of certainty that has prevailed in this area over the past 40 years cannot be explained in terms of inadequate legislation. In fact the relevant law (primarily the Health Act 1970) is not the real culprit. The real issue is that the State, through its agencies, the Department and the health boards (HSE), has been in denial as to what the law actually provides and has been acting accordingly; yet it has consistently failed to amend the law so that practice and the law are reconciled. In the case of the 2005 amending legislation, which provided for charges for in-patient services in the case of medical card holders, this came about only when it became absolutely unavoidable.⁽¹⁾

The truth, put very simply, is this:

- there is, and has been for several decades, a statutory obligation on the State to provide long-stay nursing home care for those who need it;
- the resources and infrastructure to honour this obligation have never been adequate;

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

- the State has been failing for decades to meet its obligations fully;
- the State has adopted the tactic of denying that it has legal obligations; it has offered the view that the law is unclear and uncertain and it has promised, over decades, to amend the law to bring clarity to the situation;
- the State has failed, again over decades, to amend the law comprehensively so that actual practice and the law would be in harmony with one another.

Unfortunately, there is something of a track record in the case of the Department and the health boards in failing to quite understand what the law requires in the case of older people and their right to long-term care. It is not an overstatement to say that the Department has over several decades displayed a capacity to be cavalier in its attitude to the law in this area; this is in terms both of failing to abide by primary law as well as in its making of secondary law.

The Travers Report established unequivocally that for decades the Department and the health boards maintained arrangements for charging medical card holders for long-stay care in circumstances in which they were well aware that these arrangements were illegal. These

State agencies resisted the very public urgings of the Ombudsman (see Chapter 4) that such charges were not provided for in law. Their claim was that they were operating within the law or that there was some uncertainty in the law. We now know that the Department and the health boards were in no real doubt as to what the law provided and that they persisted with an illegal charging regime because, amongst other things, of the need to maintain an important source of funding. ⁽²⁾

In 1993 the scheme of nursing home subventions was introduced. Under this scheme, patients in private nursing homes could be paid a subsidy towards the cost of their care. The subvention scheme was promoted by the Department as if older people in need of nursing home care had no existing right to be provided with care by the State. Again, this was despite the urgings of the Ombudsman (both privately and publicly) that older people had the legal right to nursing home care under section 52 of the Health Act 1970. ⁽³⁾ To compound the problem, the Department and the health boards operated the subvention scheme in a manner which was illegal.

In his 2001 “look back” report *Nursing Home Subventions*, the then Ombudsman, Kevin Murphy, dealt with this in great detail. Amongst the Ombudsman’s conclusions, for example, was that the Department had proceeded to make a regulation providing for the assessment of means of the adult children of a subvention applicant in the knowledge that this provision (“family assessment”) could not be introduced by way of regulation. In 1999, the Department dropped this family assessment provision and compensated those applicants whose subventions had either been refused, or paid at a reduced rate, because of the family assessment. What was remarkable about all of this was that, prior to its making the particular regulation, the Department’s own legal adviser had cautioned against including the “family

“[The purposes of the Health (Amendment) Bill 2005] are guided by the single key principle that there should be legal clarity regarding public services and charges. Members of the public, patients and their families deserve no less. It is not tolerable that people, particularly vulnerable people and those suffering from ill health, should be uncertain of whether they qualify for a service, or whether and how much they should have to contribute towards the cost.”

Mary Harney T.D., Tánaiste and Minister for Health and Children, Dáil Éireann (3 March 2005)

assessment” provision in the regulation.⁽⁴⁾ The Department, nevertheless, went ahead with the provision. It is perfectly fair to ask: what does this action, and other such actions, tell us about the culture within the Department? This question is particularly pertinent in the context of the present Minister’s assertion, in February 2005, that “[w]e are a society ruled by law. We must be so, and remain so, in every detail of public policy and administration.”⁽⁵⁾

What the Travers Report revealed, in particular, was a Department with an inability to face up to the challenge presented by a situation where the law and expressed Government policy were not in harmony. The Department has represented the situation as one in which it was Government policy that those receiving long-stay care should contribute to the cost of that care. It is unclear whether this policy was one of principle or simply a reflection of the view that the State could not afford to provide free long-term care for all older people who might need it. It would have been relatively easy, from a drafting point of view, to produce amending legislation to ensure the policy of charging would have a solid legal basis. Politically, this might have been less easy.

While the options open to the Department may have been politically difficult, they were otherwise straightforward: either curtail the level of entitlement by way of an appropriate amendment to the Health Act 1970 (thus ensuring resources and entitlement were in better balance) or acquire the legal authority (again, via the Oireachtas) to raise income by way of charges for services or acquire sufficient resources from the Exchequer to honour the level of entitlement actually conferred by the Health Act 1970. During the 29 year period between 1976 and 2005, the Department took none of these options. Instead, it continued with the practice of part-funding long-stay care by way of charges on all elderly patients, whether or not they had medical cards. As the present Minister has pointed out⁽⁶⁾, this illegal practice

operated through the lifetimes of 11 different Governments. When a change in the law could no longer be avoided, the Department took the course of continuing with the practice of charging medical card holders for long-stay care but, crucially and belatedly, provided a legal basis for this. This was in 2005. Similarly, if the State wishes to continue with the policy of not being obliged to provide in-patient services (including long-stay nursing home care), the correct response would be to seek to have the Oireachtas amend the law so that implementation of the policy has a legal basis.⁽⁷⁾

In the implementation of the 2005 amendment, which authorises the charging of medical card holders for long-stay care, the HSE somehow managed to mis-apply the law to the disadvantage of some long-stay residents and their families.

Arising from a complaint received by the Ombudsman in 2007, it emerged that a particular long-stay resident was being charged illegally for her care in a public nursing home. The elderly woman in question had no income of her own and thus, under the relevant legislation, was not liable to pay any charge for her care. Her husband is a pensioner and his social welfare pension includes an addition (Qualified Adult Allowance) payable in respect of his wife as his dependant. The HSE, however, decided to impose charges on the resident by reference to the Qualified Adult Allowance which it treated as her personal income. Following the Ombudsman’s examination of the complaint, the HSE agreed that this practice was incorrect and refunded the charges (€8,381) collected from the resident and her husband.⁽⁸⁾ To its credit, following a request from the Ombudsman, the HSE undertook a review to see if other such cases had arisen. In all, the HSE found 81 such cases and gave refunds in all of them at a total cost of €466,000. But for the actions of an individual who complained to the Ombudsman, these transgressions would have gone undetected and, in all probability, would

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

▶ 1998

have become standard practice. It is unfortunate that this type of mistake should occur in the implementation of new arrangements designed to correct a previous mistake.

1999

Even if one accepts the Departmental and HSE argument that the law in this area is quite confused and uncertain - and the Ombudsman does not accept that this is the case - it is quite unacceptable that the Department in particular has failed to act on its own promises, given over many years, to put matters beyond doubt. The story of one complainant, which follows below, shows how one family has had to cope while promises were being made but left unfulfilled. Details of the promises made are set out within the text below.

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Mrs B.'s Story

When Mrs B. was found to need long-stay nursing home care in early 1999 she was, as a medical card holder, entitled to be provided with a free nursing home place by her health board. In fact, Mrs B. was not provided with a place in a public nursing home and has spent the past eleven years in a private nursing home where she (with the help of her family) has had to pay very high fees. Even though the family pointed out on many occasions that Mrs B. is a medical card holder (and thus entitled to public care), and despite having asked specifically on several occasions for a public or "contract" bed, and despite having told the health board on very many occasions that she could not afford private care, Mrs B.'s needs were never met by the health board. She has continued as a private patient in a private nursing home for the past eleven years. During this period, she received no health board financial help at all for almost five of the eleven years; for three years, she received a small weekly subvention ranging from €22 to €29 per week; and since July 2007 has been receiving a subvention ranging from €383 to €402 per week. The current nursing home fees amount to €1,050 per week.

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Because of her illnesses, Mrs B. cannot manage her affairs and it has fallen to family members to act on her behalf. Her story is an unusual one in that it involves, so far, eleven years of struggle during which her family made four separate complaints on her behalf to the Ombudsman. The details set out below represent only some of the transactions as contained in the particular health board (and more recently HSE) file.

▶ 1998

In late 1998 Mrs B., then a 79 year old medical card holder, was admitted to a private hospital some days after suffering a stroke. According to her family, her GP was unable to have her admitted to a public hospital and the private hospital was the only option available. This arrangement was for a few weeks only. Mrs B. then moved to a private nursing home for a short term stay and in January 1999 she had to move again. At that stage, Mrs B. had been assessed by a geriatrician who reported:

"I reviewed this patient recently... Her underlying medical problems include dementia, cerebral vascular disease and degenerative joint disease of her knees. She falls into a maximum dependency category and requires nursing home institutional care within the [...] Health Board."

The family contacted the Health Board for assistance but contends that all it got was a list of private nursing homes. In the absence of any public bed being on offer, the family found a place for Mrs B. in another private nursing home where she has stayed in the intervening 11 years. The family is happy with the level of care provided but, unfortunately, the nursing home fees are quite high and there has been a constant struggle to meet these fees.

▶ 1999

When the family applied for a nursing home subvention in **January 1999** the application was refused. This was because the Health Board took account of the value of Mrs B.'s family home. The family contended, and continues to contend, that the home should not be assessed and that Mrs B. should not be forced to sell her house in order to meet her nursing home costs. Following an appeal, the Health Board agreed to disregard the value of the house but only for a period of six months. Even with the six month subvention, of £120 per week, Mrs B. was unable to cover the nursing home costs from the combination of subvention and her pension. Her family members were subsidising her costs.

Subsequently, one family member wrote to the Health Board about this saying: *"I believe the health board failed in their duty to assist us in this matter. The more we did the more they left us to fend for ourselves."*

▶ 2000

In **July 2000**, by which time the temporary subvention had ceased, the family asked the Health Board to re-assess Mrs B.'s case and to disregard the value of the house. The Health Board rejected this approach and refused a subvention.

▶ 2001

National Goal No. 2: Fair Access

Objective 1: Eligibility for health and personal social services is clearly defined

Quality and Fairness: a health system for you, Department of Health and Children (November 2001)

"The Ombudsman's Report on the Nursing Homes Subvention Scheme published in 2001 has raised issues regarding service eligibility and charging for long-stay care. There is a need for a clear policy on eligibility and on the balance in planning both public and private services in relation to this issue."

In **February 2001**, the family made a fresh approach to the Health Board to have a subvention paid. At this stage, the family had succeeded in renting out Mrs B.'s family home and this rental income was declared. In making this application, the family member involved wrote: *"I understand every citizen of the state to be entitled to nursing home care where absolutely needed, and request this right on behalf of my mother, and I believe the state to be failing in its duty to my mother in not providing this to her."* Again, this application was rejected and no subvention was paid.

The family appealed this decision, stressing in particular that Mrs B. is a medical card holder; it asked in the event of the Health Board not paying a subvention that it should place Mrs B. in a public nursing home. The family said that the financial burden on it was severe - that its "total family financial input" since January 1999 amounted to £45,000 in nursing home fees paid up to that date - and that this burden was not sustainable. The Health Board's appeals officer rejected the appeal but did say that the Board would be in contact with the family "with regard to your application for a contract bed". In the event, the Board did not contact the family about a contract bed; there is an internal health board letter from October 2001 saying that as Mrs B. "owns property she cannot be placed on the waiting list for a contract bed".⁽⁹⁾

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Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

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Micheál Martin T.D., Minister for Health and Children, Dáil Éireann, (19 February 2002)

"The report of the Ombudsman on the nursing home subvention scheme raised certain questions about older persons' entitlement to services. The Ombudsman outlined his interpretation of the Health Act, 1970, which is that any person in need of nursing home care has a statutory entitlement to the provision of that service by a health board. My Department's position, based on legal advice which it received, is at variance with the view expressed by the Ombudsman. What is clear is that the uncertainty that undoubtedly exists in relation to eligibility and entitlement should be resolved. The new health strategy acknowledges this and indicates that the position in relation to eligibility will be reviewed with legislative proposals aimed at bringing clarity to the situation to be brought forward in 2002."

Micheál Martin T.D., Minister for Health and Children in letter to Southern Health Board, (20 May 2002)

"It is accepted that the position regarding entitlements in this context (Ombudsman's Report, Nursing Home Subventions, 2001) is complex and that, in the interests of equity and transparency, it should be made more clear. The whole eligibility framework for health services generally is one of the key issues to be addressed in the Health Strategy. It is expected that legislation to clarify the issue of eligibility will be brought forward this year."

▶ 2003

In February 2003 the family wrote to the Health Board to say that, after four years of subsidising their mother's fees, they could no

longer bear this burden. **In May 2003**, as there had not been a response from the Board, the family again wrote to say that the situation was now "financially completely intolerable". **In June 2003**, the Health Board again rejected the subvention application. **In July 2003** a plea for help on "compassionate grounds" was also rejected. **In September 2003** the family made another subvention application, this time asking for a temporary subvention to cover the fact that Mrs B.'s house was no longer being rented and, rather than generating an income, the family needed to spend money on her house in order to make it rentable again in the future. This application was rejected by the Health Board but, on appeal, the appeals officer decided (in December 2003) to disregard the value of the house for a three month period only. This meant the Health Board would pay a subvention of €188 per week for three months.

Micheál Martin T.D., Minister for Health and Children, Dáil Éireann, (4 March 2003)

"The Health Strategy acknowledges the need to clarify and simplify eligibility arrangements and sets down a commitment to introduce new legislation to provide for clear statutory provisions on entitlement for health and personal social services. As part of the implementation process, a review of all existing legislation is ongoing in my Department. The outcome will inform the approach to the drafting of a new legislative framework on entitlements. I expect that this review will be completed in the current year and that proposals for reform will be submitted to Government."

▶ 2004

In April 2004, by which time the temporary subvention had ceased, the family again applied for a subvention. This time the

application was partially successful in that the health board awarded a small subvention of €21.70 per week. **In December 2004**, following the public controversy generated by the revelation that medical card patients had been charged illegally for nursing home care, the family wrote to the Health Board pointing out that Mrs B. had been a medical card holder prior to needing nursing home care and that her entitlement had been “overlooked and ignored by the health board”. The family sought, on behalf of Mrs B., a refund of the nursing home costs incurred up to that point.

Bertie Ahern TD, Taoiseach, Dáil Éireann, (27 October 2004)

“In line with the health strategy, the Department of Health and Children is committed to the preparation of new legislation to update and clarify the whole legal framework for eligibility and entitlement in the health services. That arose out of the Ombudsman’s report of last year.”

Mr. Dermot Smyth, Department of Health and Children, Dáil Committee on Health and Children (4 May 2005)

“There has already been much discussion of these issues at this committee. [...] it was signalled in the 2001 Health Strategy that the issue of long-stay charges required clarification. That strategy document was published at the end of 2001. The need to deal with the issue had been signalled in other health strategies before that. It was understood that as part of implementing the 2001 Health Strategy, the Department had to develop a coherent response to all the difficult eligibility issues in the system. Work was done on that and has resumed in recent weeks.”

► **2006**

In January 2006 the family sought a re-assessment of Mrs B.’s subvention entitlement. (The earlier claim for a refund of fees already paid had yielded no results.) This resulted in a small increase in subvention bringing it now to €29 per week. **In November 2006** the family again sought a subvention increase citing, in particular, an increase in the fees charged by the private nursing home. The HSE rejected this application saying that Mrs B. was already receiving the maximum subvention possible in the light of her medical and financial circumstances.

Mary Harney T.D., Minister for Health and Children, Dáil Éireann, (1 June 2006)

“The law concerning eligibility has not been changed since the early 1970s. ... the Government is working on eligibility and entitlement legislation, which will clarify which individuals are entitled to which services because greater clarity is needed in this area. [...] Until we have this legislation, we will not achieve clarity in this area. This legislation will not be ready for a number of months because it is a mammoth and very complex task.”

Sectoral Plan for the Department of Health and Children and the Health Services: Disability Act 2005 (July 2006)

“The Department of Health and Children has commenced work on a new legislative framework to provide for clear statutory provisions on eligibility and entitlement for health and personal social services. The aim is to produce a clear set of statutory provisions that ensure equity and transparency and to bring the system up to date with developments in service delivery and technology that have occurred since the Health Act 1970.”

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Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

1998

The Department is preparing draft legislation at present. The work to date has been divided as follows:

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▶ 2006

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- *Define what 'eligibility' for services means, with particular reference to the debate regarding 'entitlement' to services. This must be addressed realistically in the context of capacity and resources;*
- *Define who should be eligible for services, including the categories of eligibility and the rules governing eligibility for services;*
- *Define what services people should be eligible for, so that the eligibility system is clear and transparent. A clear and updated set of definitions of relevant health and personal services will be provided for in the new legislation;*
- *Define policy on user charges, including the principles for charging for services and the circumstances in which charges may (and may not) be levied for each service;*
- *Provide for a formal system for appeals against decisions in applications for medical cards and GP visit cards."*

▶ 2007

In July 2007, following changes in the regulations governing subvention payments, the HSE reviewed Mrs B.'s entitlement and increased the subvention significantly to €383 per week; however, the actual nursing home costs for Mrs B. now amounted to €960 per week.

Mary Harney T.D., Minister for Health and Children, Dáil Éireann, (2 October 2007)

"Work is under way in my Department on a new legislative framework to provide for clear statutory provisions on eligibility and entitlement for health and personal social

services, including appropriate charging mechanisms. The aim is to produce a clear set of statutory provisions that ensure equity and transparency and to bring the system up to date with developments in service delivery and technology that have occurred since the Health Act 1970."

▶ 2008

In July 2008 the family again asked the HSE to increase the subvention pointing out that Mrs B. was now 89 years old, confined to bed for almost ten years and had been admitted "under emergency conditions to the [private nursing home] in January of 1999 (at which time a bed in a public nursing home was not available)". The family asked that the subvention be increased by €146 per week to bridge the gap between the nursing home fees and Mrs B.'s income (including rental income from her own home). The HSE rejected this application.

Mary Harney T.D., Minister for Health and Children, Dáil Éireann, (29 April 2008)

"... the current legislation has been in place for many years and there is a need now to have a clear set of statutory provisions that ensure equity and transparency and to bring the system up to date with developments in service delivery and technology that have occurred since the Health Act 1970. Accordingly, work is under way in the Department on a new legislative framework to provide for clear statutory provisions on eligibility and entitlement for health and personal social services. The legislation will define specific health and personal social services more clearly; set out who should be eligible for what services, as well as criteria for eligibility; establish when and in what circumstances charges may be made and

provide for an appeals framework.... this is a very complex undertaking as the current legislation has been in place since 1970 [...] Given the complexities around this area, it will be necessary to obtain comprehensive legal advice in relation to the proposed legislation.”

► 2009

In February 2009 the family once again asked the HSE to increase the subvention as the nursing home fees had now increased to €1,050 per week. The family member involved told the HSE that Mrs B.’s “income cannot bear this increase” and asked how the HSE proposed to handle this. The family member pointed out that Mrs B. was then 90 years of age and that moving her from the particular nursing home, after ten years there, should not be contemplated “unless it is deemed absolutely necessary”. The HSE decision was to refuse an increase and this decision was subsequently upheld by the HSE Appeals Officer.

Mary Harney T.D., Minister for Health and Children, Dáil Éireann (12 March 2009)

“As I said earlier, the issue of what people, including older people, are entitled to in the community at large is not clear under current law. The 1970 Health Act does not define eligibility in a clear fashion. More services are being rolled out in the community, as opposed to acute hospitals. This is one of the reasons our acute hospitals are under so much pressure. Services are provided there basically free of charge, while there is a different regime in the community. Great legal clarity must be brought to the whole issue of eligibility and entitlement, and the intention is to publish legislation and enact it as soon as we can. It will be a complex and comprehensive piece of legislation.”

► 2010

Mary Harney T.D., Minister for Health and Children, Select Committee on Health and Children, (30 March 2010)

“We are preparing eligibility legislation as the Deputies will be aware. It is long overdue. We hope to be taking it to Government this year. It will clarify the items for which people are eligible in the health system. [...] It will be a major Bill and will offer a major challenge for this committee to take us through that legislation. We hope to have that this year and it should bring great clarity to the issue of medical cards and other eligibility issues.”

Department of Health and Children, Submission to Ombudsman,

(23 August 2010)

“Work is ongoing in the Department on a new and modern legislative framework in respect of eligibility and entitlement for health and personal social services. The aim is to produce statutory provisions that ensure equity and transparency and to bring the system up to date with developments in service delivery and technology that have occurred since the Health Act, 1970. The legislation will define specific health and personal social services more clearly; set out who should be eligible for what services, as well as criteria for eligibility; establish when and in what circumstances charges may be made and provide for an appeals framework.”

Complaints to Ombudsman

Over the period since January 1999, Mrs B.’s family has made four separate complaints to the Ombudsman on her behalf (in 1999, 2001, 2004 and 2009). In the case of the 1999 complaint, it appeared that the point at issue

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

► 2009

2010

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

was the inclusion in the means assessment of an imputed income derived from the value of Mrs B.'s family home. The Ombudsman accepted that the relevant regulations provided for such an assessment and that he had no basis on which to uphold the complaint.

The second complaint to the Ombudsman was made in late 2001; while, ostensibly, it raised the same issues as the earlier complaint, the context had shifted considerably. In particular, the Ombudsman had published his report *Nursing Home Subventions* (January 2001) and had articulated the view that nursing home care constituted an "in-patient service" and that this was a service to which there was a legally enforceable entitlement under the Health Act 1970. The Department disputed this view though it did accept that the law required to be put beyond doubt. Because the Department had promised to deal with these matters speedily, the Ombudsman took the view in this case, and in other such cases at that time, that it was best to await developments as promised by the Department. Accordingly, the Ombudsman did not proceed further with this complaint on behalf of Mrs B.

In December 2004 a member of Mrs B.'s family again contacted the Ombudsman. In the meantime, there had not been any developments regarding the promised Bill which would clarify entitlements for medical card holders. But the wider context had again shifted in as much as the controversy regarding the right to impose charges for nursing home care had erupted. In fact, this controversy concerned primarily the situation of people, with medical cards, in public nursing homes; but the rights of medical card holders forced by default (in the absence of public beds) into private care had also emerged as an issue.

The family argued that Mrs B. was entitled to a refund by the Health Board of the costs she (and her family) had incurred in the private

nursing home given that the private placement came about (as they saw it) because of the failure of the Health Board to provide care in the public system. In these circumstances, the Ombudsman advised the family that, before she would consider this issue, it should make a claim to the Health Board for such a refund. The family member involved agreed to this approach on the understanding that, if necessary, the family could revert to the Ombudsman on the matter. In the event, Mrs B.'s family did not contact the Ombudsman again on this particular angle of the overall complaint.

The fourth complaint was made to the Ombudsman in May 2009. The complaint arose from the rejection of the family's application, in February 2009, for an increase in Mrs B.'s nursing home subvention. It is clear from the terms of the complaint letter that the family, once again, was at the end of its tether in terms of coping with the pressures created by having to meet the private nursing home costs. Mrs B. was stated to have a very high level of debt hanging over her. At the time of finalising this report, Mrs B.'s situation remains unchanged.

With the benefit of hindsight, it is clear that the Ombudsman was perhaps misguided in expecting that all of the issues regarding entitlement to nursing home care would be dealt with clearly and comprehensively, and within a reasonable timeframe, as promised by the Department in 2001. Looking at the story of this one family, it is clear that investigation⁽¹⁰⁾ by the Ombudsman at an earlier date might well have helped accelerate the process of clarifying the law in this area.

The Department contends, with the commencement in late October 2009 of relevant provisions of the Nursing Homes Support Scheme Act 2009, that the legal situation has now been clarified. This clarification, according to the Department, is

that the State has no legal obligation to provide long-stay care for older people; however, it may subsidise the costs of long-stay care subject, amongst other things, to the availability of resources. These new provisions are considered in Chapter 7.

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Notes

(1) Health (Amendment) Act 2005

(2) *“.. there has been an understandable tendency for the former health boards, with the support of the Department, to be pragmatic and inventive in identifying sources of income. The argument is, therefore, made that the practice of charges for long-stay care over many years was essentially brought about by a shortage of Exchequer finance and justified by a belief that the practice put in place [was] underpinned by a ‘defensible legal case’ and by the principle of equity...”*

Travers Report, para. 5.13, (March 2005)

The Travers Report points out that, in fact, the case for charging was not “legally defensible” and that the legal advice available never supported such a position.

(3) *“In a context where neither the Department nor the health boards were informing people of these existing entitlements, the subvention provisions were presented as amounting to a substantial improvement on existing arrangements. This was true only in the sense that many people were not having their existing statutory right vindicated. [...] ... the 1990 Act made no substantive alteration to the existing entitlement to in-patient services. Accordingly, giving financial assistance towards the costs of private care can hardly be seen as an adequate response to the on-going failure to provide the statutory entitlement to public care.”*

Ombudsman Report, Nursing Home Subventions (2001), p. 17

(4) *ibid*, p. 50 - 52

(5) Mary Harney T.D., Minister for Health and Children, Dáil Éireann, (16 February 2005)

(6) *ibid*.

(7) The Department contends that the question of an obligation on the HSE to provide long-stay care has been put beyond doubt, since October 2009, by virtue of the NHSS Act 2009. This is considered in Chapter 7. In any event, there are hundreds of outstanding High Court actions in which this question is the key issue for adjudication.

(8) Annual Report of the Ombudsman 2008 - “Community Care home resident has in-patient service charge of €96.60 weekly reduced to nil.” See also *Investigation Report on a complaint about the imposition and collection of charges*

for in-patient services by the HSE (Sacred Heart Hospital, Carlow) available at <http://www.ombudsman.gov.ie/en/Reports/InvestigationReports/>

(9) There is no apparent legal basis for this position.

(10) The vast majority of complaints to the Ombudsman are dealt with by way of “examination” rather than “investigation”. While an examination is a detailed and time consuming process, it is a less formal process than is an investigation. In particular, an investigation generally involves a written report which, in most cases nowadays, will be published. In addition, an investigation generally will have specific findings and recommendations which, if not accepted by the public body concerned, is likely to cause the Ombudsman to make a special report on the matter to the Dáil and Seanad.

7. NURSING HOMES SUPPORT SCHEME ACT 2009 -

“...MAKING SURE WHAT HAS BEEN IN
DOUBT...”?

7. Nursing Homes Support Scheme Act 2009- “...making sure what has been in doubt...”?

The NHSS Act 2009 provides the statutory framework for the operation of a scheme of financial support for those who require long-term nursing home care. It replaces the existing scheme of nursing home subventions, in place since 1993; unlike that scheme, it applies whether the applicant is in a private or in a public nursing home.

The NHSS Act 2009 was enacted in a context where:

- very many older people in need of nursing home care were unable to access public care to which they had an entitlement;
- these older people were forced, in the absence of public care, to avail of expensive private nursing home care;
- while there was a scheme of State subventions for those entering private care, this scheme was very inadequate, operated quite inconsistently across the country and, as a consequence, many older people and their families endured hardship and stress, both financial and psychological;
- the State, through the Department, had been promising for decades that legislation to resolve all of these issues would be enacted.

The Department acknowledges that this was the situation. In fact, the NHSS Act was promoted by the Department on the basis that

“We are making fair what has been unfair. We are making consistent what has been haphazard. We are making sure what has been in doubt. What has been unsettling will be reassuring. What has been unclear will be clear.”

Mary Harney, T.D., Minister for Health and Children,
Dáil Éireann, (13 November 2008)

the existing arrangements were very unfair hence, presumably, the Department’s decision to “market” the legislation as the “Fair Deal” scheme.⁽¹⁾ For example, speaking in the Seanad on 10 June 2009, the Minister for State at the Department, Áine Brady T.D., commented:

“In short, the present situation is unfair and unsustainable. It is deeply unfair that people of the same means face radically different costs for nursing home care, depending on where they live or whether their nursing home is public or private. It is deeply unfair that one person and his or her family with modest means could face very high bills to pay for care, while another might pay relatively little even though he or she had substantial means and assets. It is deeply unfair and unsettling that so many people and their families had no other option but to sell the family home to pay for care. “

The Department, which argues that there was no existing right to be provided with nursing home care, represents the NHSS as a very positive development; those who believe there was an existing right to be provided with nursing home care, and who see the NHSS as having rescinded that entitlement, are less enthusiastic.

The Ombudsman takes no view on the merits of either of the broad policy choices. Her concern is that the State agencies should implement the law, whatever it provides. But she is also very concerned that the law should be clear and unambiguous and that the public

“Proposals for the co-financing of long-stay residential care A Fair Deal, The Nursing Home Care Support Scheme - may result in the withdrawal of an existing entitlement to which older people have a legal right. Although individual older people may take legal cases to challenge the legality of any of the above, this would constitute a significant financial and psychological burden for the individuals concerned. There are no public legal mechanisms available to older people and/or their advocates, who see their legal rights being eroded, and who wish to vindicate and protect those rights”.

National Council for Ageing and Older People, Annual Report 2007

should not be in any doubt, particularly in an area as sensitive as care of the elderly, as to the State’s obligations and the individual’s entitlements.

The question posed in this chapter is whether the enactment of the NHSS Act resolves the issues at the heart of this investigation report. To answer this question, it is necessary to establish what precisely is provided for in the NHSS Act. The position of the Department

“The Nursing Homes Support Scheme is a voluntary scheme of financial support for people in need of long-term residential care. Its basic premise is that each applicant’s ability to meet his or her own care costs is calculated and the State then commits to meeting any outstanding balance subject to the availability of resources. Thus, in the first instance, the responsibility to meet the cost of long-term residential care rests with the individual. This principle is reflected throughout the 2009 Act ...”.

Letter from Department of Health and Children to Ombudsman’s Office, (8 January 2010)

would seem to be that it deals comprehensively with the specific issue of long-stay nursing home care for the elderly but that it does not purport to deal comprehensively with the wider issue of eligibility for health services more generally. ⁽²⁾

NHSS: According to the Department ...

The following account of the NHSS Act is based mainly on a detailed letter to the Ombudsman’s Office from the Department dated 8 January 2010: ⁽³⁾

1. The NHSS Act creates a new legal category of service known as “*long-term residential care services*” (LTRCS).
2. The NHSS Act defines LTRCS as meaning “*maintenance, health or personal care services, or any combination thereof*”; according to the Department “*the definition seeks to capture what is commonly understood as long-term nursing home care ...*”.
3. The intention of the NHSS Act (according to the Department) is to draw a clear distinction between LTRCS and “*the broad range of services which may come within the term ‘in-patient services’*”; LTRCS “*is now a stand-alone concept rather than a sub-set of in-patient services*”.
4. There is no legal right to be provided with LTRCS and there is no obligation on the State to provide such a service; but the State will, subject to the availability of resources and other conditions, contribute to the cost of the service. The Department stresses in particular that responsibility for providing nursing home care rests clearly with the individual: “*In summary, then, each individual is liable to meet the full costs of their long-term residential care, although they can apply to the HSE for financial support ... in accordance with the terms of the Nursing Homes Support Scheme.*”

5. The HSE is both the administrator of the NHSS as well as being a LTRCS provider. From the individual's perspective, the financial arrangements will be the same whether he or she is in a private or public nursing home.

The Department makes it very clear that the NHSS represents a new model of provision. For decades, the Department and successive Ministers supported a model based on State provision of long-term care but with the condition (not reflected in law in the case of medical card holders) that it is reasonable and fair that people should make a financial contribution towards the costs. In essence, this was a model where the State took responsibility but sought a contribution from the individual or the family. The NHSS model is quite different. The model now is based on the principle that responsibility for long-term care rests primarily with the patient and/or family; the State **may** support the patient/family financially but this is subject to the availability of resources and to the individual satisfying a means test. Support under the NHSS is not guaranteed and the Scheme is not demand-led. If demand outstrips the availability of resources then the applicant may be placed on a waiting list until such time as resources become available.⁽⁴⁾ There is no legal entitlement to financial support.

People who avail of private care, in the absence of public care, will now have a cap on the amount they must pay for private care; this cap is expressed as a percentage of means (80% of assessable income and 5% of the value of assets). People who, in future, succeed in getting care in a public nursing home will be worse off than people in similar situations previously. This is because, under previous arrangements, the maximum charge for public long-stay care was €153.25 per week. Under the NHSS, this charge will be expressed as a proportion of the person's means inclusive of assets. A key feature of the NHSS is that the

cost to be borne by the individual will be the same whether or not the care is provided by the private or public sector. However, there is no guarantee that NHSS funds will be available

“Up to now what happened was those who were very poor went into long-stay nursing homes. They went in a queue to get state facilities and they paid 80% of their pensions. And those who had very modest means ended up in a nursing home with their families paying – I know several families who re-mortgaged their houses who have come to see me as a politician, some who would be friends, where they re-mortgaged their house to pay, so Fair Deal was to end that. Nobody will lose more than 15% of their house. I think that's a good balance between what the taxpayers will pay and what you are asked to contribute yourself.”

Mary Harney, T.D., Minister for Health and Children in *Irish Examiner*, (12 June 2010)

and (as the Department sees it) there is no longer any obligation on the HSE to provide nursing home services. ⁽⁵⁾

In fact, if the Department is correct in its analysis of the legislation, the HSE could choose not to provide nursing home services at all and leave this area of service to the private and voluntary providers. It may be contended that the State has no intention of withdrawing from direct involvement in residential care of the elderly and that it does not propose to confine its involvement to that of regulation [the responsibility now of the Health Information and Quality Authority] and the provision of cash subsidies to nursing home residents.

All of the above is premised on the understanding, on the Department's part, (a) that people have no right, under section 52 of the Health Act 1970, to be provided by the HSE with long-stay nursing home care and (b) that the HSE has no obligation to provide nursing home care to any particular person or to provide nursing home care at all.

“We must establish the right of older people to services and then impose a duty on service providers to meet those needs. The idea of rights based policies seem passé. It is as if we have done that. However, older people and their carers do not know what they are entitled to. They do not have the information ...”

Age Action submission to Joint Committee on Health and Children, (3 July 2008)

NHSS: Issues raised with Ombudsman ...

At the time of writing, the NHSS has been in operation for less than a year. Clearly, this is too brief a period on which to base any detailed assessment of the Scheme’s implementation. It is evident that in practice the NHSS does represent a considerable improvement over the more haphazard and inequitable arrangements which have been a feature of the State’s involvement, over several decades, in long-stay care for older people. At the same time, the Ombudsman’s Office has received a number of complaints, and been made aware of some particular issues, which raise some unsettling questions about the future operation and direction of the Scheme. Some of these issues are outlined below.

“Young Chronic Sick”

There is some lack of clarity regarding the type of patient whose needs are intended to be met under the Scheme. Within the HSE there was, at least for a period, a view that the NHSS applied only to those over the age of 65 years and that it was not available to those under 65 years who needed long-term residential care.

The majority of those in need of long-stay nursing home care are in the older age bracket and generally over the age of 65 years. There is a smaller group of those, under 65 years

of age and sometimes referred to as the “young chronic sick”, who also need long-stay nursing home care. Finding suitable long-term placements for this younger group is often problematic not least because long-term residential services tend (but not exclusively) to be the preserve of the HSE’s Older Persons Services. Yet the legal entitlement of these younger people to residential care, whether based on the NHSS Act or on section 52 of the Health Act 1970, is broadly the same.

Over the years, the Ombudsman has from time to time received complaints from, or on behalf of, such “young chronic sick” for whom the health board or HSE had failed to make suitable provision. One such complaint, made by the daughter of the patient in 2008, may be summarised as follows:

The complainant’s mother, Mrs. J., required long-stay care because of a medical condition (brain tumour). However, because of her relatively young age (57) the health board had no suitable long-stay placement for her and declined to place her on a waiting list for a publicly funded long-stay bed as these beds were reserved for those over the age of 65 years. According to the health board, Mrs. J. was in the category of the “young chronically ill” and so did not qualify for admission to a long-stay hospital.

As a result, and in the absence of any publicly-funded long stay placement, Mrs. J. had to go into a private nursing home. Although she eventually received full-rate subvention under the Nursing Home Subvention Scheme plus a top-up (according to the HSE paid from the Disability Services budget) to help meet the shortfall in the nursing home fees, according to her daughter all of her savings nevertheless went towards the nursing home costs. Mrs. J. died in the private nursing home in May 2005. In all, she had been three years in private nursing

home care because of the failure of her health board to provide her with the in-patient services to which she was entitled.

Mrs. J.'s daughter believed that her mother should not have had to go into private nursing home care and that she should have been provided for by the health board. Her daughter claimed under the Health Repayment Scheme for repayment of the charges actually paid by her mother prior to December 2004 (the date charges for in-patients services ceased). However, this was refused on the basis that she was a private resident in a private nursing home. Her subsequent appeal was also disallowed.

Ombudsman Comment

In effect, Mrs. J. was treated as a person with no entitlement to appropriate care for her medical condition and the most she could expect was to avail of the nursing home subvention scheme which, at the time, provided a subsidy for those who had chosen care in a private nursing home. In fact, Mrs. J. needed in-patient services and had an entitlement to be provided with such services by her health board; she availed of care in a private nursing home, not as a matter of preference, but because of the failure of the health board to provide for her. Had the NHSS been in operation, Mrs. J. might well have fared better in the sense that her own contribution to nursing home costs would have been smaller. There might, however, be a question as to whether all of her care needs would be covered under the agreed costs arrangements which apply to nursing homes participating in the NHSS - discussed further below.

Perhaps because the NHSS was developed within the Department by its Older Persons Services, there seems to have been little

anticipation of the fact that some people under 65 years old will also require long-term residential care. The Ombudsman has learned that at one point the HSE, acting apparently in consultation with the Department, decided to confine the benefits of the NHSS to those who fall within the age group served by its Older Persons Services and, accordingly, to exclude from the Scheme all persons under the age of 65 years. This decision was conveyed in an internal HSE memorandum on 16 April 2010 - see below. On the face of it, the HSE had no demonstrated legal basis for choosing to exclude all those under 65 years from the benefits of the Scheme. Indeed, the Department's own advance information material made it clear that the Scheme is not just for those over 65 years of age.⁽⁶⁾ In any event, a question must arise as to whether such an exclusion would amount to discrimination, on grounds of age, of a kind not allowed under the Equal Status Act 2000.

Very shortly following the memorandum of 16 April 2010, the HSE issued a more nuanced memorandum - see page 88 - which in effect said that, while the NHSS is open to people of all ages, younger people requiring long-stay care are likely to have needs not capable of being met under the care packages agreed with those private nursing homes participating

***“I can confirm that following a meeting in the Department ... the following position has now been adopted with regard to care groups not falling under Older Persons Services:
As and from today, no person outside the scope of Older Persons Services [those under 65 years] will be dealt with under the Nursing Homes Support Scheme. This memorandum is to inform you of the situation but further communication will issue next week when we receive the clarification in writing from the Department of Health and Children.”***

Internal HSE Memorandum, from the Assistant National Director for Older Persons, (16 April 2010)

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

in the Scheme. It seems to the Ombudsman, however, that this difficulty is not one arising from the legislation itself; rather, as dealt with in some detail below, it appears to arise from the fact that the care packages agreed with the private nursing homes cover a basic level of care only.

There is a view within the Department and the HSE that many of those under 65 years who need long-term care are likely to be people with a disability or mental health needs and that such needs are not intended to be met under the NHSS Act.⁽⁷⁾ In a letter to the HSE, dated 21 April 2010,⁽⁸⁾ the Department points out that the NHSS Act “only covers ‘long-term residential care’ which includes nursing and

personal care, basic aids and appliances, bed and board and laundry facilities”; the letter goes on to say, at least by very strong inference, that the NHSS Act does not extend to the provision of “therapies, behavioural programmes and communication devices”. This issue of restrictions on the level of service intended to be covered by the NHSS is considered further below.

However in August 2010, as this report was being finalised, the Ombudsman received a complaint which, on the face of it, adds to the confusion regarding the intended scope of the NHSS Act. The complaint concerns a young man in his early twenties with an acquired brain injury (long-term coma) who has significant assessed care needs. He has been cared for in an acute hospital for almost two years. The hospital acknowledges that it is not in a position to cater adequately for his care needs and it appears that an appropriate place in a HSE or other public facility is not available. There is a place available for him in a private nursing home which provides specialist care for patients with an acquired brain injury. However, the costs of this placement are considerable. Notwithstanding that the level of care needed by this young man is well outside the range of care covered under the NHSS, the HSE has nevertheless offered support under the NHSS towards the costs of the private nursing home. The support offered under the NHSS is not sufficient to meet the costs involved. It appears that the calculations may have been done by reference to a standard care package (negotiated, presumably, with the NTPF) rather than by reference to the young man’s actual care needs. At the time of writing, this complaint is still being examined by the Ombudsman. What is of interest, in the present context, is the fact that the HSE has sought to meet its obligations by offering support under the NHSS Act.

“I refer to my previous memo of 16 April 2010 regarding the above matter. I can confirm that following this memo, I received further clarification from the Department of Health and the following position has now been adopted with regards to care groups not falling traditionally under Older Persons Services: All persons ordinarily resident in the State are entitled to apply for long term residential care under the Nursing Homes Support Scheme Act, regardless of the care group. In order to avail of financial support under the Scheme, one must be placed in a designated facility, i.e. predominantly for the care of older persons. Where a person seeks to access care in a private facility that is seeking to charge an amount in excess of that as is approved by the NTPF, then no support shall be payable under this scheme. Accordingly, this will be a matter for other care groups to facilitate placement. The Department of Health will provide further clarification as to whether other care groups may enter into contract arrangements for long term care.”

Internal HSE Memorandum, from the Assistant National Director for Older Persons, (27 April 2010)

The Ombudsman has been made aware of a further issue arising in situations where a younger person avails of the Scheme. One recent complainant has argued that the NHSS financial assessment, as operated currently, fails to take account of the needs of families who must continue to run a household (including paying a mortgage) while also having to make a substantial contribution to the nursing home costs of a family member. This complainant observes that the NHSS was designed with older people in mind who would not have on-going mortgage and other household costs and that, as currently operated, it is unfair on families such as her own. This complainant's own account is set out below.

The complainant's spouse has had a long-term illness for many years and had to retire from work in 2003. He was cared for at home until September 2009 when he suffered a further decline. Following four months in hospital, he was transferred to a private nursing home under the provisions of the NHSS. The complainant feels that they were rushed into the NHSS without sufficient information; she also believes the NHSS is not suitable for people like her husband and herself who have a mortgage to pay as well as all of the usual household expenses to meet. After the NHSS contribution, she and her husband must pay in excess of €400 pw for his nursing home care. The extracts below are from a statement she provided to the Ombudsman in August 2010.

“In September 2009 P. suffered a further decline resulting in loss of speech and the power of his only functioning arm and hand. This was a devastating loss as any independence he had was now gone. Huge anxiety and stress followed from then in every aspect of P.'s life and that of his family. He was taken by ambulance to A&E and was admitted some time later that night.

His deteriorating condition caused a lot of concern on several occasions over the next few months. It became obvious that P. would need extended care into the future which was a lot for us as a family to accept as P. is in his early sixties. At that time another family member was also very ill and sadly died. This was an immensely stressful time in our lives. Christmas was approaching and with the weather so bad it was extremely difficult to travel between two hospitals and also travel to work.

P. remained in hospital until early 2010. In October 2009 we were told by the hospital that we would have to apply for the Fair Deal Scheme as it was the way forward in Nursing Home Care. When we asked about the Scheme and an explanation of it, we were told that it was a new scheme and it would take time to understand. So I was expected to apply for a scheme that neither I could understand nor they could explain to me. I was given a booklet that I was told would explain all! On reading the booklet we had lots of questions. The HSE were on a “go slow” at the time and several phone calls and many hours of tearful, anxious and frustrating sleepless nights were spent trying to come to terms with Fair Deal. This scheme was sold to the media and clients as being stress free and taking pressure off families and a good deal for one entering nursing home care. But in our experience this certainly has not been the case.

The hospital continued to put pressure on us as they, we were told, had 32 patients awaiting beds in A&E and needed to move P. on from the unit he was in to long term care. This was a very upsetting time, we were also phoned at home regarding this. With P.'s complex health issues, the family bereavement, the extreme weather conditions, the loss of my husband of over 30 years and now the worry of the cost of the

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Fair Deal Scheme, I was in turmoil. My doctor can verify this.

P. is fully aware of everything that is going on, he is anxious about his future and is concerned about the stress that this is causing. He was asked while in hospital if the form had been returned to Fair Deal and I feel that pressure was put on him which was totally unfair as it was out of his control. When the forms were finally sent in, it was another anxious time waiting for the reply. We worried about the cost as the allowances were very little to cope with running a house and paying bills. When we received the cost it was a big shock. I then received a call from the HSE pressurising me to sign up to the ancillary grant which I had applied for under the Fair Deal. I was given no choice at the time and did not understand what I was signing up to when I rushed into it. People we sought clarity from at that time didn't seem to understand the scheme themselves. I signed up for Fair Deal as I was advised that we would have to pay the full cost of P.'s interim hospital stay.

I received a phone call from the hospital stating that a bed had been secured in a nursing home for P. as they were moving patients on to relieve the A&E Department. We only got two hours notice of this. This was a very emotional time for P. as he was now going to a nursing home instead of coming home. He was very upset and was transferred in our absence. As customers we had to buy into nursing home care without understanding the full cost of payment into the future. P. was admitted into the nursing home without knowing the details of the costs involved. That is unfair to any client.

This is not a fair deal for people of our age group, i.e. under 65. It is definitely not a "one size fits all". We never refused to pay a fair cost. We are compliant tax payers all of

our working lives and P. still pays tax on his pension. We seem to be one of the first of our age group to have signed up to Fair Deal as quite clearly the scheme is in its infant period. The whole experience has proved to be incredibly stressful for all of our family. It is also true to say that Fair Deal is a huge intrusion on a family's privacy, for e.g. see complete application form."

While this complainant has raised a number of issues concerning the operation of the NHSS, it is not within the scope of this present report to consider them in any detail. However, on the specific argument that the financial assessment operates unfairly in the circumstances of families such as hers, it is relevant to point out that the NHSS Act ⁽⁹⁾ allows the Minister, by regulation, to extend the range of "allowable deductions" which apply to the financial assessment of NHSS applicants. The Minister could, for example, prescribe that mortgage payments on the family home be taken as an "allowable deduction" just as rent payments on one's main residence are currently allowed for in the assessment.

Range of NHSS Services

Another issue of concern is that in practice the range of services covered by the NHSS is quite narrow and excludes many elements which, on the face of it, are services which one would expect to be included as part of long-term nursing home care. Entitlement to State support under the NHSS arises only where the applicant is resident in an approved nursing home. Approved nursing homes, in the case of private nursing homes, are those which have entered into an agreement as to the maximum amounts to be charged for the provision of certain care services. The National Treatment Purchase Fund (NTPF) has been designated for the purpose of entering into such agreements with private nursing homes and has concluded such agreements as to the maximum amount

to be charged for the provision of care services. The services encompassed by these agreements, as described by the Department, “include nursing and personal care, basic aids and appliances, bed and board, and laundry services. Incontinence wear is also provided to all nursing home residents by the HSE separately to the scheme and free of charge.” However, the NTPF agreement with the nursing homes specifically excludes some fundamental care elements such as all therapies, chiropody and social programmes.⁽¹⁰⁾

The Ombudsman has received a number of complaints concerning these restrictions in what is covered by the NHSS and is aware, more generally, of dissatisfaction in this area.

For example, the Ombudsman received a complaint on behalf of one of its patients from a private nursing home in Co. Wicklow. The complaint centred on the non-availability of physiotherapy for the patient. As the nursing home explained it, provision of physiotherapy services was specifically excluded from the care package agreed with the NTPF; therefore, this service was not available from the nursing home itself. This meant that the patient would get physiotherapy only where it was paid for privately, and outside the nursing home care package, or where it was provided by the HSE. The patient’s GP requested the service from the HSE but got a reply, dated 4 March 2010, from the HSE’s Physiotherapy Service in Wicklow saying it was “currently not in a position to continue providing Domiciliary visits to Nursing Homes. This is due to current capacity in the service. Priority is being given to vulnerable clients living in a community setting.”

In complaining to the Ombudsman, the nursing home commented that “the [NHSS] does not pay for physiotherapy. All nursing home residents are refused physiotherapy and occupational therapy assessments regardless of whether their maintenance is paid for by HSE

or private means”. On 30 July 2010, following enquiries by the Ombudsman in the particular case, the HSE told the Ombudsman that it was making arrangements to visit the particular patient in the nursing home to assess his physiotherapy needs.

Another such issue was raised by two advocates who wrote to the Ombudsman on behalf of residents of a private nursing home in Co. Galway. Their complaint was that residents of that private home could not have physiotherapy and other services provided under the NHSS and, when they sought them from the HSE, service was refused; though residents of public nursing homes, they contended, were having such services provided by the Health Service Executive. The advocates wrote in March 2010:

“We represent the Residents Committee of a private nursing home, with a majority of our residents being medical card holders, where services such as Physiotherapy, Chiropody, Speech and Language, Optical and Dentistry are not being provided by Community Care Services, HSE. It has come to our attention, that residents in public nursing homes are being covered for such services as mentioned above.

This is a very cold and callous approach to the administration of a scheme, essentially for the Elderly, the sickest and the least well off, who are sometimes unable to speak for themselves ... [this] smacks of discrimination against the Elderly in our private nursing homes.

Would you please clarify the current position with regards to providing these therapies to residents in private nursing homes, who are medical card holders, as we feel that these therapies are crucial at this stage of the residents’ lives, and being medical card holders should be entitled to the same

“Along with improved standards, the Fair Deal Scheme has removed a large number of inequities that were present in the state system of care. However, we have expressed our concerns regarding the capping of funding for the Scheme and the possibility of waiting lists emerging as a result. Combine this with the number of supporting healthcare goods and services that are excluded from coverage by the Scheme, and there is a danger that the inherent benefits and more equitable approach of Fair Deal may be severely undermined.”

Nursing Homes Ireland in a letter to the Ombudsman, (22 July 2010)

privileges as residents in public nursing homes.”⁽¹¹⁾

The Department appears to take the view that the exclusion from the NHSS care packages, as agreed by the NTPF, of therapies and other service items is not detrimental to the patients concerned. It explained this as follows⁽¹²⁾:

“A person’s eligibility for other schemes, such as the Medical Card Scheme or the Drugs Payment Scheme, is unaffected by the Nursing Homes Support Scheme. In other words, a person can continue to receive goods and services in accordance with the terms of these other schemes regardless of whether they are in a nursing home or elsewhere. A person can also receive therapy services provided by or on behalf of the HSE separately to the scheme and regardless of whether they are in a public or private nursing home.”

This statement would be unexceptional if it were the case that, for example, therapy services were already available outside of the Scheme. In fact, the availability of therapies from the HSE, whether for older people living at home or for those in residential care, seems to be patchy and inconsistent. It appears to be the

case that the HSE has only a limited capacity to provide services such as physiotherapy, occupational therapy and chiropody and there have been claims (as above) that residents of private nursing homes (NHSS beneficiaries) are sometimes treated as not eligible for such services - though they might well have benefitted had they continued to live in their own homes or gone to a public nursing home.

The Department appears to acknowledge, at least indirectly, that there is a problem regarding the provision of therapies to NHSS beneficiaries in private nursing homes. The Department’s position is that the issue of providing therapies should be dealt with comprehensively rather than in the context of the NHSS alone:

“... the Department refers to the transcripts of the Dáil Committee Stage reading of the Bill where the Minister stated that the issue of therapies would be dealt with in eligibility legislation rather than within the Nursing Homes Support Scheme Act 2009. The Minister also outlined her rationale for this approach which was to deal with the issue of therapy services in a comprehensive, population health based manner and to safeguard against the Nursing Homes Support Scheme acting to divert resources away from the community and towards nursing home care. This rationale is consistent with Government policy which acknowledges the preference of people to remain in their own homes and communities for as long as possible and which endeavours to support them in achieving this through the provision of community-based long-term care services.”⁽¹³⁾

In preparing this report, it appeared to the Ombudsman that the care packages agreed between the NTPF and the nursing homes reflect an approach to care services which is narrower than that envisaged in the NHSS Act. The exclusion from the care package of therapies and social programmes appeared

to be at odds with what (in the words of the Department) “ is commonly understood as long-term nursing home care ...”.

Furthermore, it appeared that the care packages provided for in the NTPF agreements are not consistent with the obligations placed on private nursing homes under the Health (Nursing Homes) Act 1990 (as amended) and the Health Act 2007 (including regulations made under the latter Act) ⁽¹⁴⁾. The Ombudsman was concerned that, in many individual cases, the NTPF agreed care packages were not adequate to meet the actual care needs of that individual and that, in this event, the agreements made by the NTPF were falling short of the level of care apparently envisaged under the NHSS Act. However, a careful reading of the NHSS Act suggests that the narrow care packages agreed by the NTPF may not necessarily be at odds with the provisions of the Act.

Long-term residential care services means

The NHSS Act contains 48 sections and two schedules. It is, unfortunately, a complex piece of legislation. However, the thrust of the Act is that it provides for State financial support towards the costs of “care services”. This latter term is defined as meaning “long-term residential care services”. And this term, in turn, is defined at section 3 as follows:

“ long-term residential care services ”—

(a) subject to paragraph (b), means—

(i) maintenance, health or personal care services, or any combination thereof, provided by or on behalf of the Executive to a person—

(l) whilst the person resides in and is maintained in a facility—

(A) that is publicly designated in writing by

the Executive as a facility predominantly for the care of older people, which designation shall, subject to section 33 (2), specify the health or personal care services to be provided at that facility, and (B) in which nursing care is provided on the basis that at no time should there be less than one registered nurse present in the facility who is available to provide nursing care for the persons maintained in the facility, and

(ll) subject to subsection (2), for—

(A) a period of not less than 30 consecutive days, or

(B) periods in the aggregate amounting to not less than 30 days within a period of 12 consecutive months, or

(ii) maintenance, health or personal care services, or any combination thereof, provided to a person whilst the person resides in and is maintained in an approved nursing home—

(l) in which nursing care is provided on the basis that at no time should there be less than one registered nurse present in the approved nursing home who is available to provide nursing care for the persons maintained in the approved nursing home, and

(ll) subject to subsection (2), for—

(A) a period of not less than 30 consecutive days, or (B) periods in the aggregate amounting to not less than 30 days within a period of 12 consecutive months,

(b) does not include—

(i) medically acute care and treatment in an acute hospital,

(ii) respite care,

(iii) rehabilitative care for—

(l) a period of less than 12 consecutive months, or (ll) periods in the aggregate amounting to less than 12 months within a period of 24 consecutive months, or

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

(iv) out-patient services made available pursuant to section 56 of the Health Act 1970 ;”

This definition deals separately with (i) services provided in a facility by or on behalf of the HSE and (ii) services provided in an approved nursing home (which, in effect, means a private or voluntary nursing home). For present purposes, the focus is on the latter.

The definition envisages three possible elements of care (*“maintenance, health or personal care services”*). The NHSS Act does not define what constitutes maintenance or health or personal care services. While at first glance it may seem that all three elements are required to be provided, this is not the case. As pointed out to the Ombudsman by the NTPF, *“[t]he Act does not ... envisage that the services should include all possible maintenance health and personal care services”*. ⁽¹⁵⁾

Applying the usual rules of statutory interpretation, it is clear that the definition of LTRCS is met where any one of the three, or any combination of the three (whether a combination of two or of three), of the elements applies. Thus, the provision of maintenance by itself, to the exclusion of health and personal care, would seem to meet the definition. Similarly, the provision of personal care by itself, to the exclusion of health and maintenance, would seem to meet the definition. Or the provision of health and personal care, to the exclusion of maintenance, would seem to meet the definition - and so on. Somewhat oddly, it seems that one could envisage LTRCS being provided without any need to include nursing services, for example.

While the definition of LTRCS is quite elastic, as suggested above, there is a further twist in the overall story. The LTRCS definition is qualified by the proviso that it applies (leaving aside the HSE’s own nursing homes) only where the care is provided in an “approved nursing home”.

Thus, in order to understand what is comprised in LTRCS one must have regard to the definition of “approved nursing home”. There is a lengthy definition of this term but, for present purposes, the critical element is this:

*“ approved nursing home ”—
[...]*

(b) means ... a nursing home—

(i)[...]

(ii) in respect of which there is in force an agreement in writing, between the proprietor of the nursing home and a designated person [NTPF] , as to the maximum amount that will be charged for the provision in the nursing home of such care services as are specified in the agreement which fall within paragraph (a)(ii) of the definition of “long-term residential care services” (or classes of such care services) to those persons who are maintained in the nursing home and who have made an application for State support”

What this appears to mean is that the content of LTRCS, in terms of the services to be provided to the patient, depends ultimately upon the agreements made between the NTPF and the private nursing homes. The definition of LTRCS given in the NHSS Act sets out very broad parameters; what LTRCS constitutes in reality depends upon the choices and decisions of the designated person (NTPF).

While the NTPF says that its only role is to *“is to negotiate prices with private and voluntary nursing homes on behalf of the State”* ⁽¹⁶⁾, it seems clear from the legislation that this is not the case. The job of the NTPF is to enter into agreements as to the maximum charges *“for the provision ... **of such care services as are specified in the agreement** which fall within paragraph (a)(ii) of the definition of ‘long-term*

residential care services ...” (our emphasis). These agreements specify the range of services to be provided as well as the maximum charges for those services. There appears not to be any provision in the NHSS Act under which either the Minister or the HSE can set out ground rules for the NTPF (either in terms of pricing or range of services) or can overrule an agreement entered into by the NTPF.⁽¹⁷⁾ It does seem that the NTPF, on this occasion, has acted on the basis of *“the list of services to be priced provided to NTPF by the Department”*⁽¹⁸⁾; but, if so, it appears there is no legal obligation on it to act on the basis of advice from the Department or, indeed, from any other source.

The NTPF has clarified that its involvement in this area is not as agent for the HSE; rather, it stresses that it is acting in its own right under section 40 of the NHSS Act. For its part the HSE, in its response to the draft of this chapter, pointed out in relation to the range of services covered under the NHSS that it is *“not within the gift of the HSE to determine what care components are included”*.

It is remarkable that the NTPF, as the “designated person”, appears to be given a free hand to decide which elements of “maintenance, health or personal care services” are to be covered in the agreements with the private nursing homes. It is remarkable also that, in the course of the Oireachtas passage of the NHSS Bill, there appears to have been virtually no debate on the definition of “long-term residential care services”.

In summary, therefore, the position regarding LTRCS seems to be as follows:

1. In order to understand what the NHSS Act intends to be included within the categories “maintenance, health or personal care services”, one must look both at the Act itself and at the agreements entered into with the nursing homes by the designated person (NTPF).
2. While the NHSS Act appears to provide for the “maintenance, health or personal care” needs of older people, in reality, it need only meet some of these needs rather than all of them.
3. The decision as to which needs will be met (and which will remain unmet) is a matter for the NTPF acting as the “designated person” in relation to private nursing homes.
4. In exercising its function, the NTPF appears to have a free hand and there is no legal basis on which either the Minister or the HSE can seek to influence the NTPF’s actions.
5. In practice, the NTPF has chosen (at least for the time being) to align its agreed care packages with those applicable in the case of residents in HSE nursing homes.

Does NHSS Act Re-Define “In-Patient Services”?

The key issue here is whether, as the Department contends, the NHSS Act amends the Health Act 1970 in such a way as to put beyond all doubt that there is not a residual right, under section 52 of the 1970 Act, to be provided with nursing home care as an aspect of in-patient services.⁽¹⁹⁾ In addressing this, there are two separate matters to be considered. The first of these is the issue of how the new LTRCS interacts with the existing legal category of in-patient services; and the second involves the legal construction of the amendments made to the Health Act 1970 by the NHSS Act 2009.

Interaction of the Provisions

On the face of it, though the Department disputes this, LTRCS appears to constitute a sub-set of those elements of care which comprise in-patient services. While there is no single comprehensive statement of what constitutes in-patient services, the Supreme Court has identified some of the key elements in its judgment in *McInerney*⁽²⁰⁾ where it noted

“Under the Nursing Home Support Scheme, more commonly known as the “fair deal”, St Monica’s is now required to negotiate a so-called “bed price” with the National Treatment Purchase Fund. The “fair deal” covers bed, board and basic nursing care but does not include aspects of St Monica’s service which are considered essential aspects of care, such as physiotherapy, chiropody, alternative therapies, hairdressing, social activities, outings etc. These “extras” will now have to be paid for by the residents themselves (who already contribute 80 per cent of their pension) or by their families. Inevitably, this will be a serious diminution of care.

[...] Through inspections which St Monica’s has passed with flying colours, one arm of the State, Hiqa (the Health Information and Quality Authority), rightly demands the highest standards of care and compliance, while now another arm of the State is demanding cuts that inevitably will result in a lowering of those standards.”

Alan Gilsean, “Real care does not reside in the building or its facilities, but rather in the spirit of the people within”, *Irish Times*, (28 September 2010)

that Ms. McInerney was receiving *“the nursing care requisite for a patient of her age and state of health in a geriatric institution”* and that the *“regimen of treatment ... involves nursing ... supervision, activation and other para-medical services, which are given in an institutional setting. In other words, what she is getting is ‘in-patient services’, which she requires because she is a geriatric patient.”* On the basis of this account of in-patient services, it is clear that there are many people whose long-term care needs will not be met fully within the restricted LTRCS range of services. For example, older people who have an assessed need for any of the therapies or other care elements excluded from the definition of LTRCS (as reflected in the NTPF agreements) may have their care needs met in part - but

not met in full. Even more so is it the case that people, of any age, with significant physical and/or intellectual handicaps will not have all of their care needs met under long-term residential care services.

The question arises whether people whose care needs can be met partially, but not fully, under LTRCS should avail of the Scheme at all and whether, in the alternative, such people should rely solely on their entitlement to in-patient services under the Health Act 1970. There appears to be some confusion and inconsistency of practice in relation to this question.

In order to avail of the NHSS, a person must undergo a care needs assessment. This assessment takes account of a range of criteria, for example, cognitive ability, mobility, degree of continence, ability to feed and dress oneself, ability to communicate and so on. The focus is on the person’s ability to care for himself or herself. The outcome of the assessment is a determination that the person does, or does not, “need care services”. There is nothing in the NHSS Act to suggest that a person whose care needs are very extensive - requiring a level of care far beyond that actually covered by LTRCS - should be excluded from the Scheme; such a person will inevitably be assessed as needing “care services”. The question then is how that person (where he or she avails of the NHSS) will have the balance of care needs met.

There is considerable confusion as to whether people whose full care needs cannot be met under LTRCS should avail of the NHSS at all. On the one hand, it is clear that some older people currently availing of the NHSS have care needs (such as physiotherapy) which are not catered for under the Scheme and which require additional payments. On the other hand, the HSE and the Department appear to hold the view that the NHSS is not intended for

people with care needs not capable of being met within the restricted scope of long-term residential care services. This view appears to apply in particular to people with care needs arising from major disabilities. At the same time, the Ombudsman is aware (as mentioned earlier in this chapter) of one instance in which a young man with major care needs, not covered by the limited scope of LTRCS, was nevertheless offered support under the NHSS towards the costs of a specialist private nursing home.

The Ombudsman takes the view that, in circumstances where a person's care needs are not met in full under the NHSS, there is a continuing right to rely on section 52 of the Health Act 1970 to have the remaining care needs met. If this were not the case, it would mean that a person would lose the existing statutory right to have all care needs met (under in-patient services) as a consequence of availing of a discretionary financial support (under the NHSS Act) towards the costs of a narrower range of care services. Furthermore, it appears to the Ombudsman that a person in need of in-patient services (which includes elements of care covered under the NHSS) may choose not to avail of the NHSS Act and opt, instead, to have his or her needs met under section 52 of the Health Act 1970.

Legal Construction of Amendments

The Department contends that the NHSS Act 2009 creates the new service category of LTRCS and that this has the effect of re-defining the existing in-patient services category. Under this re-definition, nursing home type care should be seen as excluded from the ambit of in-patient services. The Department's position, it appears, is that people whose need is for LTRCS are not people who need in-patient services. In effect, (under the Department's approach) the range of people with care needs hitherto encompassed by in-patient services has been narrowed by the

removal of those whose need is for long-term residential care services. This appears to be its position notwithstanding the fact that many people who avail of the NHSS will have needs not met under that Act.

The NHSS Act 2009 amends section 52 of the Health Act 1970 with the insertion of a new sub-section (1A); section 52 of the Health Act 1970 now reads as follows:

“Provision of in-patient services.

52.— (1) *[The HSE] shall make available in-patient services for persons with full eligibility and persons with limited eligibility.*

(1A) The Health Service Executive may make available long-term residential care services within the meaning of the Nursing Homes Support Scheme Act 2009.

(2) A health board shall make available in-patient services for children not included among the persons referred to in subsection (1) in respect of diseases and disabilities of a permanent or long-term nature prescribed with the consent of the Minister for Finance.

(3) [not relevant in this context]”.

The NHSS Act 2009 also amends section 53 of the Health Act 1970, the section dealing with charges for in-patient services, with the insertion of new sub-sections (1A), (1B) and (1C); the 2009 Act also adds a new section 53A. The relevant portions of these provisions are reproduced below.

“Charges for in-patient services.

53.— (1) *Subject to subsection (1A), charges shall not be made for in-patient services made available under section 52 except as provided for in subsection (2).*

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

(1A) Charges shall be made for long-term residential care services in accordance with the Nursing Homes Support Scheme Act 2009.

(1B) A reference in subsection (1A) to long-term residential care services shall be construed as a reference to long-term residential care services within the meaning of the Nursing Homes Support Scheme Act 2009 as respects such services provided to a person who first begins to receive those services after the coming into operation of section 6(1) (c) of the Nursing Homes Support Scheme Act 2009.

(1C) A person in respect of whom charges are being made under subsection (2) shall not be required to pay charges under subsection (1A).

(2) - (8) [not relevant in this context]".

"Charges for in-patient services in certain cases

53A.— *(1) This section applies where in-patient services (not being long-term residential care services within the meaning of the Nursing Homes Support Scheme Act 2009) are provided to a person in a hospital for the care and treatment of patients with acute ailments (including any psychiatric ailment) and a medical practitioner designated by the Health Service Executive has certified in writing that the person in receipt of such services does not require medically acute care and treatment in respect of any such ailment.*

(2) Where this section applies, notwithstanding section 53, charges may be made in respect of in-patient services on the basis specified in subsection (3) as if those services were long-term residential care services within the meaning of the Nursing Homes Support Scheme Act 2009

provided by the Health Service Executive, and whether or not the person concerned has made an application for State support under section 9 of that Act.

(3) The charges referred to in subsection (2) shall be determined by the average cost of long-term residential care services as determined by the Health Service Executive in facilities operated by the Health Service Executive and publicly designated in writing as facilities predominantly for the care of older people.

(4) - (5) [not relevant in present context]".

The Department considers that, LTRCS is "a distinct, stand-alone category, rather than a 'sub-set' of in patient services though, in reality, little or nothing would appear to turn on this point". ⁽²¹⁾ In fact, much does turn on this point since, if the Department is correct, this would mean that the definition of in-patient services would, consequent on these amendments, be changed significantly.

One difficulty here is to know what LTRCS actually means in that, as outlined above, it does not necessarily involve the provision of each of the three elements ("maintenance, health or personal care services"). In principle, LTRCS need not even include nursing care and, in fact, it explicitly excludes physiotherapy and other therapies. Thus, even if one accepts that the package of services which constitute LTRCS is no longer comprised in the definition of in-patient services, there is an uncertainty as to what LTRCS actually means.

The position being adopted by the Department seems highly implausible. On the one hand, there is the long-standing statutory health service category (in-patient services) which is mandatory and whose extent is reasonably well delineated. On the other hand, there is the new category of statutory health service (LTRCS)

which is discretionary and whose extent is not well delineated. It seems unlikely that the Oireachtas intended to replace the relative certainty attaching to the former with the relative uncertainty attaching to the latter. Or, if so, one would expect this radical shift to be set out expressly in the legislation.

An Alternative Meaning?

Sub-section (1A) of section 52 is an insertion into a section carrying the side-title “**Provision of in-patient services**”; and the amendments to section 53 are made to a section carrying the side-title “**Charging for in-patient services**”. In the case of section 52, it does not seem logical to seek to provide for a new and separate category of service within a section dealing with an existing category of service. Similarly, in the case of section 53, it is not logical to provide for charges for this new service in a section titled “**Charging for in-patient services**”.

Logically, and having regard to the structure of the Health Act 1970 as a whole, if the Legislature intended to provide for a new category of service - separate and distinct from in-patient services - and for charging for this new service - then one would expect this to be provided for in a stand alone section or sections. Furthermore, and more significantly, if it was the intention of the Legislature to curtail an existing statutory entitlement, and particularly one of such importance to a vulnerable though sizeable group within society, then one would expect this to be set out explicitly. In this regard, the 2008 comments of the Chief Justice seem relevant:

“... where the Legislature is enacting provisions, however sound the reasons for them may be, which have potentially serious implications for legal rights, including constitutional rights, of persons or corporations, one must expect that the intended ambit or application of such

provisions will be expressed in the legislation with reasonable clarity.” (22)

It is difficult to argue that the “ambit or application” of the above NHSS provisions is “expressed ... with reasonable clarity”.

There is a possible construction which gives meaning to sub-section (1A) of section 52 while not limiting the entitlement created by sub-section (1). This is that LTRCS is introduced in sub-section (1A), and in the amendments made to section 53 as well as in the new section 53A, in order to allow for the charging regime associated with the NHSS Act to be applied to the provision of in-patient services in the case of long-stay care of the elderly. The effect of this would be that the charging regime associated with the NHSS Act would be applied to people availing of in-patient services on a long-term basis where the level of care required is less than that normally associated with acute hospital treatment. This would mean that two separate charging regimes would apply to people availing of in-patient services - one for those receiving acute care and another (more costly) regime for those receiving in-patient services on a long-term basis - but, in both instances, the patient would still be receiving in-patient services. This would mean where the HSE is providing long-stay care to a patient, whether in a nursing home type establishment or in an acute hospital, that the same charging regime will apply, that is, the regime provided for in the NHSS Act. If this construction is correct, then there is no change to the existing requirement that the HSE “make available” in-patient services.

Response of Department

In the course of this investigation the Ombudsman’s Office sought clarification from the Department as to its understanding of the effect, from an entitlement perspective, of the amendments to sections 52 and 53 of the Health Act 1970. The clarification was sought

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

in the context that the overall impact of these changes was far from clear. In particular, the Ombudsman's Office pointed out that the amended section 52 requires the provision of in-patient services whereas it simply enables (without requiring) the provision of long-term residential care services. It is difficult to envisage that the scope of an existing statutory entitlement was intended to be restricted by virtue of the introduction of a new discretionary service.

The Department gave a detailed written response, dated 8 January 2010, the key elements of which are set out below:

"... the Department does not accept that section 52(1) gives rise to a legally enforceable, unqualified, obligation to provide in-patient services to persons with full eligibility, still less to 'the entire population' as you appear to suggest. That remains the Department's position. Section 52(1A) (inserted by the 2009 Act) does not affect that position but is wholly consistent with it. Subsection (1A) relates to the new category of service defined by the 2009 Act, namely "long-term residential care services". The provision of "in-patient" services continues to be governed by section 52(1), subject of course to the provisions of section 53 in relation to charges (as amended by the Health (Amendment) Act, 2005).

You note that section 52(1) uses the term "shall" whereas section 52(1A) refers to "may". The Department is advised that, as a matter of principle, it is not appropriate to interpret a statutory provision by reference to a subsequently-enacted provision. In any event, the Department's position as regards section 52(1) is as set out above and the Department does not accept that any difference in terminology as between section 52(l) and section 52(l A) is material in this context. ⁽²³⁾

Insertion of Section 53A within the Health Act 1970

You specifically ask whether section 53A (1) relates to the imposition of charges on patients in receipt of in-patient services but who are not patients receiving long-term residential care services. The purpose of section 53A is to enable the application of charges to people in acute hospital beds who have finished their acute phase of care. The provision allows such individuals to be charged in respect of in-patient services 'as if those services were long-term residential care services'. It further provides that such charges shall be determined by the average cost of long-term residential care provided by the HSE. The rationale underpinning this provision is to remove the incentive to remain inappropriately in an acute hospital bed when long-term residential care is more appropriate. This policy rationale is clearly outlined in the Oireachtas debates on the legislation."

While it may be clear what the Department intended to achieve with the NHSS Act 2009, and the related amendments to the Health Act 1970, it is much less certain that these intentions have been given proper statutory expression. The amendments to the Health Act 1970 are key to the Department's assertion that LTRCS now constitutes a separate category of service and that, as a consequence, the in-patient services category no longer includes nursing home care as an integral element. One might reasonably expect that this would have been spelled out in the Dáil and Seanad, particularly in dealing with those provisions of the Bill which provided for amendments to the Health Act 1970. The Ombudsman's Office has been unable to find any explicit elaboration on these provisions in the Oireachtas debates on the Bill. At Committee Stage, in both Houses, these provisions were characterised as "technical" and no elaboration was given. It is difficult to reconcile this characterisation

with the far-reaching consequences of these amendments as claimed by the Department and described above. ⁽²⁴⁾

The Ombudsman does not purport to give a definitive view on how the relevant legislation should be interpreted but does offer the comment that the situation is far from clear and that this lack of clarity may well give rise to further litigation. In view of the time and very significant effort which the Department undoubtedly expended in the preparation of the NHSS Act 2009, it is most unfortunate that the final product does not achieve that level of clarity and certainty which would be to everyone's benefit.

The Department appears to accept the validity of this analysis in the case of disabled people ⁽²⁵⁾ whose needs cannot be met within the restricted LTRCS ambit. Such people, therefore, remain within the ambit of section 52 of the Health Act 1970. The same logic must apply also in the case of older people who have an assessed need for any of the therapies or other care elements excluded from the definition of LTRCS (as reflected in the NTPF agreements). On the one hand, such older people do not have their needs met under the NHSS; on the other hand, their needs are such as to fall within the understanding of in-patient services as clarified by the Supreme Court in *Mclnorney*. It may well be the case, therefore, that many older people currently availing of the NHSS, but all of whose care needs are not provided under the NHSS, should continue to be regarded as persons in need of in-patient services. This analysis, if found to be correct, could have major implications in terms of liabilities into the future for the HSE and the State.

Plain language and the Law?

It is undeniable that much of the health legislation analysed and quoted in this report is quite impenetrable and fails to meet any reasonable test of being comprehensible to the

ordinary person. These deficits have to do with the language used (for example, see the NHSS Act's definition of LTRCS) and with the structure of the legislation (for example, see the amended versions of sections 52 and 53 of the Health Act 1970).

That the law should be written in language which is reasonably easily understood is a concern raised ten years ago, in 2000, by the Law Reform Commission; this concern is expressed on a few separate occasions in its report *Statutory Drafting and Interpretation: Plain Language and the Law*:

“The principle of the Rule of Law presupposes that those who are affected by a law should be able to ascertain its meaning and effect. A system of language and law understood by only a few, where only a few have the ability to make authoritative statements about what is and is not permitted under the law, cedes power to those few. Lord Simon of Glaisdale wrote: ‘It is important to remember why our statutes should be framed in such a way as to be clearly comprehensible to those affected by them. It is an aspect of the Rule of Law. People who live under the Rule of Law are entitled to claim that the law should be intelligible. A society whose regulations are incomprehensible lives with the Rule of Lottery, not the Rule of Law.’

“The principle of the Rule of Law presupposes that those who are affected by a law should be able to ascertain its meaning and effect. A system of language and law understood by only a few, where only a few have the ability to make authoritative statements about what is and is not permitted under the law, cedes power to those few.”

Statutory Drafting and Interpretation: Plain Language and the Law, Law Reform Commission, 2000 [LRC 61 - 2000]

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

(Lord Simon of Glaisdale, The Renton Report - Ten Years On, 1985, Stat. Law Rev. 133) ⁽²⁶⁾ [...]

There is a clear need, in the case of some legislation, that it should be addressed to, and readily comprehensible by, the ordinary citizen...there is an argument from principle that, since legislation does ultimately affect and regulate the lives of all citizens, it should be capable of being understood by the reasonably well-educated layperson. ⁽²⁷⁾ [...]

It is important not to lose sight of the fact that legal documents and statutes are not meant to be works of art or literature, but are documents whose primary aim is to communicate. As working documents intended to do a job they should be designed for utility rather than beauty. " ⁽²⁸⁾

Legislation dealing with the right to nursing home care falls, undoubtedly, into that category of legislation which "should be addressed to, and readily comprehensible by, the ordinary citizen". It is very regrettable, ten years following this Law Reform Commission report, that legislation is being drafted with no apparent

"Isn't there something odd that the laws, by which we govern ourselves, are largely incomprehensible to us, the people, in whose name the laws are enacted? Actually it is even worse than that, for many (most?) of the laws are incomprehensible to the elected representatives who enact them and to whom we subcontract our self-government. Worse still, we have a legal priesthood who divine what it is we have meant by the Acts passed in our name, and what it is our grandfathers and grandmothers meant by the Constitution, enacted 73 years ago. And this priesthood expresses itself in language and at such length that the majority of the self-governing people could not possibly understand."

Vincent Browne, *Irish Times*, (26 May 2010)

regard for the Commission's recommendations.

More recently, the Government's White Paper *Regulating Better* (2004) covered much of the same ground. The White Paper promotes the view that legislation - both primary and secondary - should be both clear and consistent and that applying the principles of Better Regulation ⁽²⁹⁾ will improve the quality of our everyday lives (as well as supporting competitiveness). The White Paper says of these principles:

"In addition to benefits as consumers, applying these principles to new and existing regulations will improve the quality of our everyday lives. Red tape is at best frustrating and, at worst, it alienates people by placing barriers between the Government on the one hand, and citizens and communities on the other. Sometimes this is because of the quality of the regulations themselves - they might be drafted more with a focus on the administrator than on those whom they are designed to assist or protect. Sometimes it can be because there is confusion as to the structures and processes that are in place for dealing with particular issues. There may be overlap or duplication between regulatory authorities. There might be a lack of clarity on appeals procedures and who is responsible for what. The new principles that we are proposing will mean that we will systematically review and take account of these issues. The goal is to achieve a more coherent regulatory framework and to improve the quality of our everyday lives."

Regrettably, there is little if any evidence from the NHSS Act 2009 that the principles of Better Regulation were taken into account in its drafting. ⁽³⁰⁾

The Ombudsman’s conclusions regarding the NHSS Act may be summarised as follows:

- in practical terms, it represents an improvement for many older people and their families;
- it appears not to take reasonable account of the needs of families where there is a mortgage to be paid and ordinary household expenses to be met;
- it is not at all apparent that the creation of the new category of service (LTRCS) modifies the existing definition of in-patient services; if the Oireachtas had intended to change the definition of in-patient services, it would have done so explicitly;
- it does not affect the right to in-patient services of those requiring long-stay care whose needs are greater than those captured in the definition of LTRCS;
- it does not deal, one way or the other, with the issue of whether the right to in-patient services is a legally enforceable right;
- it is a poorly drafted Act which fails to meet any reasonable standard of clarity and is unlikely to be comprehensible to the average citizen or, indeed, even to the “reasonably well-educated layperson”;
- after less than a year of its operation, there are worrying indications that the NHSS Act is being applied in a minimalist manner which may, ultimately, be found to be incorrect;

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Notes

(1) For the purposes of this report, the legal title term, the Nursing Homes Support Scheme (NHSS), is preferred.

(2) *"Great legal clarity must be brought to the whole issue of eligibility and entitlement, and the intention is to publish legislation and enact it as soon as we can. It will be a complex and comprehensive piece of legislation."*

Mary Harney, T. D., Minister for Health and Children, NHSS Bill Committee Stage debate, (12 March 2009)

(3) Despite its position that the Ombudsman does not have the jurisdiction to undertake this investigation, the Department replied to specific queries concerning the NHSS for this report.

(4) There is some risk that NHSS funding during 2010 will be inadequate: *"There is an emerging trend in May 2010 of a significant increase in payments to private nursing homes, which if continued, could result in expenditure which is higher than originally projected. The application process for Fair Deal is being closely monitored to determine the possible trend for the remainder of 2010. We will advise the Board should the limit of funding for the scheme be reached."* [HSE Performance Report, May 2010 (Issued 8 July 2010) - <http://www.hse.ie/eng/services/Publications/corporate/May2010PR.pdf>] However, in its July **Performance Report** (issued 9 September 2010) the HSE states that *"it is envisaged that there is sufficient funding available to meet the scheme's requirement in the current year ..."*.

<http://www.hse.ie/eng/services/Publications/corporate/july2010performancereport.pdf>

(5) In the event of NHSS funds running out in any year, a question arises as to whether this will affect public and private nursing homes equally. Where annual funding is fully committed, new subventions for patients in private nursing homes will not be awarded; but it is unclear as to whether new patients, opting for public nursing homes, will be similarly affected.

(6) *"Is this scheme just for people over-65? No, the present subvention scheme does not make a distinction on age grounds and the new arrangements will not either. The service and the population for which the [Nursing Homes Support Scheme] will be provided is defined in the legislation"*. **Frequently Asked Questions** document (July 2009) Department of Health and Children

(7) *"... [THE NHSS] applies only to approved private nursing homes and designated public facilities which are predominantly for older people and as such these units are often not suitable placements for younger people."* HSE submission to Ombudsman (P. 12)

The Department appears to see services for disabled people as a separate category of service and not one associated with in-patient services. But the Health Act 1970, which is still the legal basis for service provision and entitlement to service, has no service category called "disability services". (The only substantive references to disability in the Health Act 1970 are at sections 68 and 69 dealing with training of disabled persons for employment and with payment of maintenance allowances, respectively.)

A disabled person who needs residential care involving any one or more of the elements of nursing, supervision, therapies, rehabilitation would seem, on the face of it, to need "in-patient services". This suggests that those under 65 years of age who need long-term residential care, and in particular where there is a need for rehabilitation and on-going therapies, are in a no-man's land. This is hardly correct and cannot be what the Oireachtas intended.

(8) This letter appears to have been prompted by discussions regarding a particular group of patients who, in the Department's view, require *"disability services rather than long-term residential care services in a nursing home"*

(9) Under section 36(3) of the NHSS Act 2009

(10) The NTPF has provided a copy of one such agreement which the Ombudsman takes to be a reasonable reflection of what these agreements contain generally.

(11) The Ombudsman advised the advocates that the issues should be raised directly with the HSE before she could become involved. The advocates then advised the residents and their families of their right to complain to the HSE but are unsure whether any complaints were made. In the meantime, the Ombudsman understands that the nursing home has arranged some physiotherapy and chiropody services for its residents. These services are not covered under the agreement with the NTPF and the nursing home says that it is absorbing these costs itself. However, the nursing home pointed out that it had one resident, a stroke victim, with a need for speech therapy and that it was unable to provide this service (which is not covered under the NTPF agreement).

(12) Para. 130 of Department's Submission

The HSE has recently established a working group to look into these issues; its draft terms of reference are to *"undertake a national review of current provision to private nursing homes, public and voluntary units and make*

recommendations with regard to introducing equity of access and cost including the following services: Therapies (Physiotherapy, OT, Dietetics, Speech & Language, Chiropody), Specialist nurse / services e.g stoma nurse, Continence wear,”.

(13) Para. 133 of Department’s Submission
The Health (Repayment) Scheme Act 2006 provides for the establishment of the Repayment Scheme (Donations) Fund to which people, entitled to a refund of in-patient charges, may instead donate the refund or a part thereof for the purpose of *“providing improvements in public health services provided to dependent older persons and persons with disabilities and the expenses of which are non-recurring and are not expenses which would, in the ordinary course of the provision of such public health services, have otherwise been expenses met by an allocation from the Minister for Finance or another Minister of the Government.”* This Fund is administered by the HSE which allocates money from it to appropriate purposes. The HSE has identified a number of items of expenditure which can properly be met from the Fund; these items include the *“provision of therapy facilities”*. (Source: *Report of the Comptroller and Auditor General 2009* - Para. 41.45) This suggests the HSE regards the costs of providing therapies for dependent older persons as costs not ordinarily arising under the State funded health service.

(14) Under the terms of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 each nursing home resident is now required to be the subject of an individual care plan which, presumably, identifies the specific elements in an overall care programme. In many instances, care plans will include services such as chiropody, physiotherapy or occupational therapy. All residents will require some social activities and, indeed, this is expressly provided for in the 2009 Regulations which require that each resident be provided with *“opportunities to participate in activities appropriate to his/ her interests and capacities”* as well as *“facilities for the occupation and recreation of residents”*.

(15) NTPF letter to Ombudsman’s Office, 23 September 2010

(16) <http://www.ntpf.ie/section40/roleOfTheNtpf/>

(17) In a letter of 13 July 2009 to Nursing Homes Ireland the Minister for Health and Children represented the role of the NTPF as simply one of *“negotiating on a price”*; the Minister said that the NTPF *“will not be negotiating on the*

volume, range or quality of service to be provided”. This was because, as the Minister expressed it, *“the goods and services that constitute [LTRCS] will be effectively circumscribed by the information laid before the Houses of the Oireachtas by the Minister for Health and Children”*. This appears not to be correct. The information required to be laid before the Houses by the Minister is concerned solely with *“facilities”* operated by, or on behalf of, the HSE; there is nothing in the NHSS Act to support the view that this *“information”* (consisting of details of the goods and services which comprise LTRCS) has any application in the context of private nursing homes. In practice, though it appears it was free to have done otherwise, the NTPF has taken the list of goods and services drawn up by the Minister in relation to public beds and negotiated agreements with the private nursing homes for a similar package of services.

(18) NTPF letter to Ombudsman’s Office, 23 September 2010

(19) In the course of this investigation, the Ombudsman’s Office told the Department that the report would represent its position on the extent to which the NHSS Act amends section 52 of the Health Act 1970 and said it was *“likely to rely on the explanation of these developments as outlined by the Minister (or Minister for State) as the 2009 Act was being taken through the Dáil and Seanad. As the Oireachtas debates on the 2009 Act are quite voluminous, it would be of great assistance to us if the Department could refer us to those extracts from the Dáil and Seanad debates where these developments were outlined to the members of the Houses.”* (Letter of 1 February 2010). In its reply, dated 2 March 2010, the Department said: *“...the Oireachtas debates are extensive, and the Department would not wish to in any way confine or otherwise circumscribe your own examination of these records.”* The Department referred the Ombudsman to the Oireachtas debates but declined to identify any particular speech or extract.

(20) [1976 - 1977] ILRM 229

(21) Letter of 8 January 2010 from Department.

(22) Murray C.J. in *Bupa Ireland Limited and Another v Health Insurance Authority and Others* [2008] IESC 42

(23) The meaning of this paragraph is far from clear.

(24) *“Section 32 is a technical provision ensuring the*

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

existing legal basis for charges, including the exclusion of certain care groups from charges, is maintained. Section 33 is also a technical provision. In line with the Government's commitment, it ensures existing public residents will not be worse off as a result of the new scheme. It also provides that a person in an acute hospital bed who has finished his or her acute phase of care may be charged as if he or she were in receipt of long-term residential care services. This provision is necessary to ensure there is not a legal incentive to remain in an acute hospital bed following discharge."

Mary Harney, T. D., Minister for Health and Children, NHSS Bill 2008 Second Stage debate, (13 November 2008)

In addition, the Explanatory Memorandum accompanying the Nursing Homes Support Scheme Bill 2008 states as follows: "Section 32 enables the HSE to charge for long-term residential care services. Section 33 amends Sections 52 and 53 of the Health Act 1970. In particular, it provides that a person paying public charges does not have to pay contributions under the Nursing Homes Support Scheme Act".

(25) In 2009 there were 8,997 disabled adults in residential care (Source: *Report of the Comptroller and Auditor General 2009* - Para. 45.2)

(26) *Statutory Drafting and Interpretation: Plain Language and the Law*, Law Reform Commission, 2000 [LRC 61 - 2000], viii

(27) *ibid*, p. 71

(28) *ibid*, p. 75

(29) The White Paper identifies what the Government sees as the principles of good regulation:

"NECESSITY - is the regulation necessary? Can we reduce red tape in this area? Are the rules and structures that govern this area still valid?

EFFECTIVENESS - is the regulation properly targeted? Is it going to be properly complied with and enforced?

PROPORTIONALITY - are we satisfied that the advantages outweigh the disadvantages of the regulation? Is there a smarter way of achieving the same goal?

TRANSPARENCY - have we consulted with stakeholders prior to regulating? Is the regulation in this area clear and accessible to all? Is there good back-up explanatory material?

ACCOUNTABILITY - is it clear under the regulation precisely who is responsible to whom and for what? Is there an effective appeals process?

CONSISTENCY - will the regulation give rise to anomalies and inconsistencies given the other regulations that are

already in place in this area? Are we applying best practice developed in one area when regulating other areas?"

(30) On this, see Ita Mangan, "Deficiencies of the Law Relating to Care of Older People in Older People" in *Modern Ireland - Essays on Law and Policy*, Eoin O'Dell (ed.) (2006). Ms. Mangan suggests that the Better Regulation principles appear to be applied only in the area of economic regulation.

Deputy Neville: ... the Department exploring the issue of entitlements for medical card holders in private homes who fail to obtain places in public nursing homes? Mr. Smyth (Department of Health & Children): We are exploring this matter, which is part of the broader issue of eligibility. As legal cases are pending I cannot say much on the subject.” LITIGATION issue of whether everyone over 70 is entitled to a bed funded by the State, and if a bed in a public facility is not available, whether the State must fund a bed in a private nursing home, is being tested in the Courts. ... I do not know how this will be determined.” LITIGATION “Has the Department accounted for the pending court cases of those who were forced to take beds in private nursing homes? Some people tried to get beds in public nursing homes but were unable to do so. As a second choice, they opted for private nursing homes. If the court rules that these people are also entitled to compensation, the figure will be much higher. What progress is being made on this?” LITIGATION “Proceedings have been instituted in 306 cases, involving patients who spent time in private nursing homes. None of the cases have yet proceeded to a hearing Consequently, it is considered inappropriate to estimate any potential future liability or to detail the uncertainties attaching thereto since to do so might prejudice the outcome of court proceedings.” LITIGATION “It would seem likely then that the State has been unjustly enriched at the expense of the in-patients [who have been charged unlawfully in public hospitals] ... It would also seem likely that patients who made private arrangements under a practical compulsion or necessity or a mistake similarly unjustly enriched the State. It would also seem likely that any deduction from the State’s income in respect of the charges made, the plaintiffs would be entitled to maintain personal actions in restitution for recovery of the deductions, and would in principle be entitled to simple (if not compound) interest at Court Act rate.” LITIGATION “The Department claims that the issue is being dealt with in the Courts. [...] it does not matter a damn whether issues are before the Courts because, if a problem arises with legislation, we are supposed to act. It will be two or three years before this issue goes through the Courts. [...] We are already repaying €1 billion in respect of charges for public nursing homes and if we also end up repaying charges for private institutions on the basis of flawed legislation, the money provided through the Health (Repayment Scheme) Bill will be small change in comparison. If we continue to skirt the problem by saying it is before the Courts, we may be telling people in three years’ time that serious problems have arisen which will cost the taxpayer €3 billion.[...] LITIGATION “While I have a responsibility to be as straight with this committee as possible, I also have a responsibility to the State to protect its position in court cases. I would be wary about saying more than that. We received advice and are following it. Given that it has been raised in parliamentary questions, Deputy Twomey would know that, as Mr. Smyth mentioned, apart from the legality of it, we are examining the policy issues around residential care for older people regardless of whether they are in public or private beds.” LITIGATION “ There shall be vested in the Attorney-

8. LITIGATION -

“... LEGAL UNCERTAINTY IS TESTED AND EXPLOITED...”?

8. Litigation - “... legal uncertainty is tested and exploited...” ?

At the time of writing, the State is defending in the High Court more than 300 legal actions taken by or on behalf of people who claim that their right to long-stay nursing home care has not been honoured. The defendants are the HSE, the Minister for Health and Children, Ireland and the Attorney General or various combinations of these.

Initially, these legal actions fell into two broad categories: (a) claims arising from the illegal imposition of charges on medical card holders while being provided with in-patient services by the health board (HSE) and (b) claims from people forced into private nursing home care because of the inability of the health board (HSE) to provide them with a long-stay placement. It appears that the claims of the first category have to a large extent been subsumed into the Health Repayment Scheme ⁽¹⁾ and that the outstanding legal actions relate very largely to the second category. The Ombudsman’s interest here is with this latter category - people who are seeking to be compensated for the costs they incurred arising from the State’s failure to provide them with a service to which, they contend, they had a legal entitlement. Because their care was provided in private nursing homes, these people are excluded from benefitting under the Health Repayment Scheme. ⁽²⁾

This present investigation does not extend to include the manner in which the Department

and the HSE have been handling this litigation; and the Ombudsman, accordingly, will not be making any specific findings or recommendations in relation to how these public agencies have conducted the litigation. However, any consideration of how the Department and the health boards (HSE) have been dealing with the issue of long-stay nursing home care must, inevitably, reflect the fact that this litigation exists. In fact, the key legal issue arising in this investigation - whether section 52 of the Health Act 1970 creates an enforceable right to in-patient services (including nursing home care) - is one likely to be settled definitively by the Courts in the event that any of the individual actions proceeds to hearing. The Ombudsman was reluctant to undertake an investigation in this area on the assumption that this key legal issue would be resolved through the Courts. In the event, more than five years have gone by and the matter has not yet gone to hearing in the Courts. In these circumstances, it is reasonable to have regard to the existence of this litigation in the wider context of this present investigation.

In responding to a draft of this chapter, both the Department and the HSE sought to represent the Ombudsman as trespassing on the domain of the Courts and, indeed, (as the HSE put it) “attempting to influence the outcome of court proceedings”. The Ombudsman rejects absolutely that this is the case. There are two points, in particular, which must be made: the **first** is that the analysis of the relevant provisions of the Health Act 1970 set out in this report is neither novel nor unique to the Ombudsman; the **second** is that it is quite unthinkable that a judge of the Superior Courts would be anything other than objective and unbiased notwithstanding any public commentary on legal issues yet to be decided. Neither is it plausible that there might be any perception among the public generally that a judge of the Superior Courts would be likely to be influenced by the public utterances of the Ombudsman.⁽³⁾

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

The Department and the HSE have refused to provide the Ombudsman with any information on the legal actions in question; they have withheld even the most basic of information such as the number of cases initiated or a broad description of the nature of the claims made. Not surprisingly, therefore, neither was the Ombudsman given any information on how the State has been defending these actions nor whether any of them have been settled or otherwise disposed of in court. Nevertheless, it has been possible to build up a general picture from other sources, including from the Courts, of the extent of the litigation and of the issues being raised. ⁽⁴⁾ In particular, very specific information on the nature of one such case has been given in a recent decision by the Master of the High Court and it seems safe to assume that this case is typical of such cases generally. This decision ⁽⁵⁾ involves three separate cases one of which (with the HSE/Minister for Health and Children as defendants) concerns the right to in-patient services of a person who, it is claimed, had to take up private care in the absence of health board (HSE) care. (The other two cases involved, respectively, the Minister for Agriculture and Galway County Council.) The overall number of legal actions initiated appears to have been in excess of 400 cases of which it seems about 340 are active cases at present.⁽⁶⁾

Grounds for Actions

In simple terms, the claims appear to be (a) grounded on the alleged failure of the State to meet its statutory obligation, under section 52 of the Health Act 1970, to provide in-patient services to medical card holders and (b) involve a claim for compensation or damages for the costs incurred by the individual plaintiff in having to arrange and pay for private nursing home care. During the period to 2005, the health boards were required to provide long-stay care (in-patient services) to medical card holders free of charge; since 2005, health boards (and now the HSE) have been entitled to charge medical card holders for long-stay care.

The plaintiffs claim that the service they require, but have had to source privately, is the same as that provided to the plaintiff in *McInerney* ⁽⁷⁾ which, as held by the Supreme Court, is in-patient services under section 52 of the Health Act 1970. The plaintiffs reject the distinction drawn by the Department between “entitlement” and “eligibility” and contend that this distinction is not valid in law. The plaintiffs rely in broad terms on the contents of the Travers Report and on what that report reveals regarding the manner in which the health boards and the Department had acted illegally, over several decades, notwithstanding strong legal advice that they were not acting in accordance with the Health Act 1970. The plaintiffs are seeking restitution and damages.

In technical legal terms, the plaintiffs are claiming negligence (breach of statutory duty to make available in-patient services free of charge), that the Health (In-Patient Services) Regulations 1993 are *ultra vires* the Health Act 1970, that the actions of the defendants are unconstitutional and that there has been unjust enrichment and misfeasance in public office. ⁽⁸⁾ Overall, the Master of the High Court has observed that in the particular case before him “[t]he *ultra vires* element in the claim is the mainstay of the case”.

“Deputy Neville: Is the Department exploring the issue of entitlements for medical card holders in private homes who fail to obtain places in public nursing homes?”

Mr. Smyth (Department of Health and Children): We are exploring this matter, which is part of the broader issue of eligibility. As legal cases are pending I cannot say much on the subject.”

From Travers Report Presentation before Joint Committee on Health and Children (4 May 2005)

Some of these actions have proceeded to the stage of seeking orders for discovery in which the plaintiffs have sought a wide range of documentation including: health board files on the individual’s case, Departmental documents [internal and communications with the health boards (HSE)] going back several decades and dealing with the availability of resources, the allocation of resources, guidance on how to operate charging for public long-stay care and documentation provided to the Ombudsman in the course of the investigation which led to the 2001 report *Nursing Home Subventions*.

In defending these actions, it appears the State bodies are relying on the following lines of argument:

- meeting obligations under the Health Act 1970 is subject to the ability and/ or capacity of the health boards (HSE) to make the particular service available and subject to the availability of resources having regard to all of their responsibilities, obligations and commitments;
- that it is a matter for the health boards (HSE) to determine, within existing financial and budgetary constraints, the allocation of monies to particular health services and/ or to particular persons claiming entitlement to those services;
- that, in the circumstances prevailing, it would be inequitable to require the defendants to make restitution at this stage;
- the defendants also plead separation of powers, statute of limitations, delay and that the proceedings constitute an impermissible collateral challenge to administrative decisions, actions and/ or omissions.

Strangely, it is not evident from the information already in the public domain that the State bodies are relying overtly on its fundamental argument that section 52 does not create an

enforceable entitlement; that it provides for eligibility rather than for actual entitlement.

Progress of Claims - Settlements

At the time of writing, none of these cases has gone to hearing and judgment in the High Court. This is rather surprising given that many of the cases were commenced more than five years ago and given the importance for the

“The issue of whether everyone over 70 is entitled to a bed funded by the State, and if a bed in a public facility is not available, whether the State must fund a bed in a private nursing home, is being tested in the Courts. ... I do not know how this will be determined.”

Mary Harney T.D., Minister for Health and Children, Dáil Éireann, (1 June 2006)

State of having a judicial adjudication on what it is required to do by virtue of section 52 of the Health Act 1970.

The Ombudsman’s Office is aware that settlements have been reached in about a dozen of these cases.⁽⁹⁾ It seems that the settlements involved some level of payment by the State to the plaintiffs. The details of these settlements are not available and it appears that they contain a confidentiality clause under which the plaintiffs are constrained from disclosing the settlement terms. From what can be gathered it appears that, while many of the plaintiffs have sought orders of discovery, presumably having failed to achieve voluntary discovery, court-ordered discovery does not appear to have been made in any of these cases; though the HSE says (in its response to a draft of this chapter) that “voluntary discovery has been made in many cases to date”. While the HSE and the Department have dismissed it, the question certainly arises as to whether the State side becomes amenable to settlement in situations in which an order of discovery has become likely; that is, rather than have its

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

documentation provided to the plaintiff, the State opts for a settlement.

If this were the case, then this would be a repeat of the practice which prevailed within the health boards for many years when medical card patients were being charged illegally for long-stay care. The practice then was to ensure no case actually came to hearing before the Courts thus avoiding a judgment which would have wider implications. In effect, the practice then was one of “buying off” the individual patient, by way of a settlement, while continuing with the practice generally. This was something which attracted critical comment from the Minister for Health and Children in the aftermath of the Travers Report; she commented in the Dáil on 23 March 2005:

“The advice they [health boards] were getting from the Department for many years, going back to 1978, was that they should not contest [legal actions to recover hospital charges]. Therefore, if one long-term bed occupant had a lawyer who could help him or her to take a case, he or she would no longer be charged while somebody not so fortunate in the bed beside him or her was charged in all those years. Besides the legal issues involved here, there are significant inequality issues that are unacceptable”.

“Has the Department accounted for the pending court cases of those who were forced to take beds in private nursing homes? Some people tried to get beds in public nursing homes but were unable to do so. As a second choice, they opted for private nursing homes. If the court rules that these people are also entitled to compensation, the figure will be much higher. What progress is being made on this?”

Senator Fergal Browne, Joint Committee on Health and Children, (22 June 2006)

There may always be a temptation to settle individual cases in circumstances in which one is on weak legal ground on an issue which has prompted litigation from a large number of people. As is clear from the illegal charges issue, this was a temptation to which the State succumbed in the past. Arising from that experience, and in the light of the present Minister’s critical comments on the matter, one would expect that stratagem to be avoided for the future. It appears that a change in our law might be necessary in order to introduce measures to counteract the temptation to follow such a stratagem. Two TCD legal academics have proposed that we adopt the practice of the US courts where, notwithstanding that an issue has become “moot” by virtue of a settlement, the courts may deal with an issue

“... where the alleged wrong is ‘capable of repetition, yet evading review’. The adoption of a similar approach here would enable Irish courts to go behind a settlement in order to rule authoritatively on the legal issues raised which, notwithstanding the settlement, would continue to affect the legal rights of many people who were not party to the litigation. The public goal attained here would be that of ensuring proper compliance with the law on the part of public bodies and thwarting the type of stratagem used to such good effect (from their perspective) by the authorities in the instant situation [illegal charges] for the best part of thirty years.”⁽¹⁰⁾

In the immediate context of this report, the question remains as to whether those who initiate legal action, and who succeed in bringing that action to an advanced stage, are being treated more favourably than those, whether in identical circumstances or otherwise, who are not in a position to take legal action. ⁽¹¹⁾ The same *inequality* issues mentioned by the Minister must, presumably, also be unacceptable in the present context.

The position in relation to settlements is confusing. The Department, at para. 56 of its response to the draft version of this report, comments:

"Moreover, when dealing with litigation, the Minister must be conscious of the interests of the taxpayer and must seek to protect the interests of taxpayers. The Minister - and, by extension, taxpayers - are not required to compensate people who have no legal entitlement to compensation. The public interest requires that claims for which there is no legal basis are defended."

Leaving to one side the great likelihood that the plaintiffs in these cases are themselves taxpayers, or former taxpayers, the fact is that some of these plaintiffs have been compensated notwithstanding the Department's assertion that they are people with *no legal entitlement to compensation*. The HSE, for its part, explains (at page 16 of its response):

"... in general terms, the HSE is required to use its resources in the most efficient way possible. If this means seeking to settle a particular case in circumstances where it makes economic sense to do so, rather than engage in lengthy and expensive legal proceedings, then the HSE is perfectly entitled to make such decisions. To do otherwise might be criticised as an unnecessary waste of public funds. Neither is it appropriate to assume that it is always the HSE who might insist on, or seek, a confidentiality agreement."

While the pragmatism espoused by the HSE may be appropriate in specific circumstances, one must question whether it is appropriate in the circumstances of these cases. The overriding consideration should be to achieve clarity, as speedily as possible, regarding the claims of the plaintiffs and the obligations of

"Proceedings have been instituted in 306 cases, involving patients who spent time in private nursing homes. None of the cases have yet proceeded to a hearing Consequently, it is considered inappropriate to estimate any potential future liability or to detail the uncertainties attaching thereto since to do so might prejudice the outcome of court proceedings."

HSE Annual Report and Financial Statements 2009

the health boards (HSE). Settling individual cases would seem to delay the achieving of this clarity. The HSE rejects any view that it is involved in "tactical delays" in its dealings with these cases and asserts (also at page 16 of its response) that *"the reason why no case has come on for hearing [is] that advisors to many of the Plaintiffs are concerned that the Defendants have a valid full defence"*. It is intriguing that the State side would agree to settlements, involving compensation, if it believes that it has a *valid full defence*. In fact, it must be asked whether it is a breach of statutory duty for a statutory body to settle litigation, involving costs to the Exchequer, in circumstances where it believes it has a *valid full defence*. And this question is even more relevant where there are very many other litigants with claims almost identical to that of the person whose case has been settled. If (as is apparently being suggested by the HSE) it were the case that plaintiffs were failing to progress their cases, because of a lack of confidence in their cases' legal merits, it would be open to the defendant State side to seek to have those cases struck out for failure to prosecute.

The fact remains that, whatever the factual circumstances behind the individual plaintiffs' cases, all of them turn ultimately on the same issue of law. One would expect it to be a priority to have this issue of law decided. If the issue is decided in favour of the State side then,

“It would seem likely then that the State has been unjustly enriched at the expense of the in-patients [who have been charged unlawfully in public hospitals] ... It would also seem likely that patients who made private arrangements under a practical compulsion or necessity or a mistake similarly unjustly enriched the State. It would also seem likely that any defences to such a claim would fail. As a consequence, the plaintiffs would be entitled to maintain personal actions in restitution for recovery of the deductions, and would in principle be entitled to simple (if not compound) interest at Court Act rate.”

Eoin O’Dell in *Older People in Modern Ireland - Essays on Law and Policy*, Eoin O’Dell (ed)

presumably, all of the plaintiffs’ claims will fail; if the issue is decided against the State side then the factual circumstances of each plaintiff will have to be proven in order to establish an entitlement to compensation. This is precisely the point made by the Master of the High Court in a recent decision.⁽¹²⁾ The Master raised issues to do with the costs of litigation in cases involving the State as defendant. Taking three separate cases before him, involving respectively the Minister for Agriculture, Galway County Council and the HSE/Minister for Health and Children, the Master proposed that in such cases it would be more efficient and save considerably on costs were the underlying legal issue to be decided in principle and in advance of deciding the factual circumstances of the individual plaintiff. The attraction of this approach increases very significantly where, as in the cases at issue here, there are several hundred actions in existence each of which turns on the same issue of law.

The procedural arrangements for the conduct of this litigation are not necessarily within the control of the HSE and the Department. At the same time, declining to become involved

in settlements might well have the effect of ensuring that one or more of the cases will come to hearing, and judgment, sooner rather than later. It has to be in the interests of all of the parties that there is a speedy outcome. From the State’s point of view, in a worst case scenario, a negative judgment in the Courts could leave it exposed to claims for compensation far in excess of that under the Health Repayment Scheme. If only in the interests of prudent financial management, it is reasonable to expect that the State side should do everything possible to ensure that legal certainty in this area is achieved.

The State and Litigation

In the normal course, any State body is entitled to defend itself in court when it has an action taken against it. However, there is something quite unsettling about litigation initiated by or on behalf of vulnerable members of society in a context where the objective is to clarify the rights of the plaintiff and the obligations on the defendant State body. Frequently, these cases come about as a last resort, only after all of the other usual avenues of redress have been attempted without success. One thinks, for example, of cases taken in recent years by parents of special needs children who were seeking to clarify the extent of their children’s entitlement to special education provision⁽¹³⁾; or, in a related area, the series of cases taken some years ago on behalf of at-risk children in need of protection by way of secure accommodation. The common factor in this type of litigation is that the law as it stands is unclear. In many instances also, including the subject matter of this report, there has been a persistent failure on the part of the State to clarify the law even though the difficulties with it are well known.

The Minister for Health and Children has shown a keen awareness of the need to achieve clarity in the law, and thus reduce recourse to the Courts for purposes of interpretation. Speaking

in the Dáil on 3 March 2005 ⁽¹⁴⁾ she remarked:

“In an increasingly litigious society, legal uncertainty is tested and exploited in many ways that are, to say the least, not always in the public interest. The cost to the public and taxpayer of achieving legal clarity is highest when it comes from protracted and repeated litigation. The cost is lowest when it comes from coherent policy, meticulous law-making and professional public administration.”

In some instances of this type of litigation, there may (as the Minister seemed to be suggesting) be an element of exploitation by the plaintiff of legal loopholes. But where the point at issue is the extent of the State’s obligation to older people generally, or to children, or to the disabled, it seems unwarranted to infer that such cases are prompted by the self-interest of the plaintiff or of his or her lawyers.

It may be inevitable, in circumstances where litigation has been initiated, that a defendant’s response will be guided and managed by lawyers. Where the defendant is the State, and the plaintiff is a member of the public drawn from a vulnerable group within society, the manner in which the litigation is conducted can be quite unsettling. Lawyers, speaking generally, are trained to behave in an adversarial fashion and tend to operate according to the somewhat arcane rules of behaviour which apply in court. The issue becomes one of winning or losing and all of the many weapons available in the legal armoury are likely to be deployed in an effort to win the case. This can include tactical delay, the threat of costs being awarded against the plaintiff, obfuscation, introduction of irrelevant arguments, misrepresentation and much more besides. In fairness, lawyers on both sides may be prone to conducting business in this fashion. But in a case taken by a citizen against his or her own State, and on a matter of genuine public interest, it should not become a matter of

winning or losing. The real issue has to do with serving the public interest. Nevertheless, it does seem on occasion that the response of State bodies to litigation may be based more on protecting the interests of the body itself than on serving the wider public interest.

In fact, the State has on occasion behaved very unacceptably in defending court actions. Probably the most notorious example of such unacceptable behaviour is the case of the late Mrs Brigid McCole who, in 1995, sued the Blood Transfusion Service Board (BTSB) and the State arising from her having contracted Hepatitis C from contaminated blood products. ⁽¹⁵⁾ What attracted such negative comment in that case was that the State side allowed the litigation to proceed for almost 15 months, notwithstanding that Mrs McCole was seriously ill (she died in October 1996) and in the full knowledge that it would be found liable for her illness. The case was defended by the State in a manner which was recognised afterwards to have been unnecessarily adversarial and aggressive. Indeed, the State’s handling of this legal action was subsequently the subject of a report by Ms. Fidelma Macken SC, commissioned by the Minister for Health and

“The Department claims that the issue is being dealt with in the Courts. [...] it does not matter a damn whether issues are before the Courts because, if a problem arises with legislation, we are supposed to act. It will be two or three years before this issue goes through the Courts. [...] We are already repaying €1 billion in respect of charges for public nursing homes and if we also end up repaying charges for private institutions on the basis of flawed legislation, the money provided through the Health (Repayment Scheme) Bill will be small change in comparison. If we continue to skirt the problem by saying it is before the Courts, we may be telling people in three years’ time that serious problems have arisen which will cost the taxpayer €3 billion.[...]”

Liam Twomey T.D., Joint Committee on Health and Children, (22 June 2006)

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Children in 1997. In publishing this report in August 1997, the then Minister (Brian Cowen T.D.) was very critical of the manner in which the State (and the B.T.S.B.) defended the action taken by Mrs McCole. For example, the Minister commented:

“The Hepatitis C/Anti-D issue is the biggest health scandal in the history of the State. Yet, despite the gravity of the crisis and the fact that over 1,000 people were directly impacted by it, Minister for Health Noonan chose to adopt a strategy which was more concerned with the pure legal principles and technical obligations, than effecting a fair, just and humane solution to Mrs McCole’s plight. The approach adopted was bereft of compassion or sensitivity to Mrs McCole or to the interests of others who were infected through the negligence of a State institution. [...]

Even allowing for the fact that Court proceedings are adversarial by nature, the fact that the State was aware, at an early stage, that the B.T.S.B. had a case to answer and because of the nature and magnitude of the problem, the adversarial approach should have been tempered and the contentious tactics dropped.

[...]

“While I have a responsibility to be as straight with this committee as possible, I also have a responsibility to the State to protect its position in court cases. I would be wary about saying more than that. We received advice and are following it. Given that it has been raised in parliamentary questions, Deputy Twomey would know that, as Mr. Smyth mentioned, apart from the legality of it, we are examining the policy issues around residential care for older people regardless of whether they are in public or private beds.”

Michael Scanlan, Secretary General, Department of Health and Children, Joint Committee on Health and Children, (22 June 2006)

The lack of desire to seek a solution which recognised that a fundamental wrong was done to a citizen of the State is the biggest indictment of the State’s legal approach and strategy in Bridget McCole’s case. “⁽¹⁶⁾

The Ombudsman is not suggesting that the plight of those elderly, denied public long-stay care over the years, is on a par with the tragic circumstances of the late Mrs McCole and of others who suffered as a result of the blood scandal. Nevertheless, there are some valid points of comparison not least in the fact that vulnerable members of society have felt compelled to go to court to seek to vindicate a basic right. In responding to these actions, it would be hard to conclude that the State has sought a “fair, just and humane solution” or that the usual adversarial response has been in any way “tempered”.

It does seem that reliance on an adversarial court system, as a tool for dealing with matters of fundamental importance to vulnerable groups in society, is not appropriate. At a meeting of the Joint Committee on Health and Children on 22 June 2006, Senator Fergal Browne appears to have had similar thoughts when he posed the following question:

“The Travers report refers to being correct about the legal basis for decisions. If the Department is concerned about the legality of an issue, is there scope to take a legal test case? In this way it would not be obliged to wait until a member of the public took a case. The Department could be proactive.”

In his reply, the Secretary General at the Department said:

“If we receive legal advice from the Attorney General, we do not then go to court and take a test case. We will act on that advice. I will take away what the Senator stated on the idea of test cases. I would have thought we

would only consider that if the Office of the Attorney General stated it was the correct course of action.”

Whether the Department had further thoughts on this suggestion is unknown.

In his recent decision, the Master of the High Court suggested that the procedures followed in public law litigation need to be reviewed urgently. The Master’s comments arise primarily from a concern about the costs of such litigation - met mostly from the public purse - and he makes some specific suggestions to secure “*cost effective and speedy trials [which] can only be regarded as contributing to the perception and reality of justice*”. While the Master notes the need for a “*culture change on the part of both parties*”, he specifically proposes that “*the State should not be so insistent on proving that it is never wrong.*”

In the context of the litigation involving the right to nursing home care, the Department and the HSE argue that the financial cost of conceding the legal actions is prohibitive; that it is in the public interest to resist the actions because of the enormous cost implications.⁽¹⁷⁾ In effect this would be an argument that, even if the law is on the side of the plaintiffs, we cannot now afford to admit this and pay the price. It would also be an argument that bad behaviour in the past, while perhaps not being rewarded, should be absolved.

In fact, we need to distinguish between acknowledging the existence of a right (for example, to be provided with nursing home care) and the separate matter of how best to compensate people who have been systematically, and over a period, denied their rights. If a question arises of compensating people whose rights have been disregarded, it is not necessarily always in the public interest that such people should be compensated fully and immediately. But it is most definitely in the public interest that rights should be recognised.

The issue of restitution for loss of rights is also a public interest matter but it involves a balancing of several public interest considerations as to how restitution can best be achieved and over what period.

Public Interest Guardian?

The constitutional role of the Attorney General (AG) is to “*be the adviser of the Government in matters of law and legal opinion*” (Article 30.1). In addition, the AG has a function conferred by statute law in the “*assertion or protection of public rights*”⁽¹⁸⁾ sometimes referred to as the AG being the guardian of the public interest. In its Mission Statement in the past the AG’s Office included the statement that the Attorney “*may exercise a role as representative of the public for assertion or defence of public rights other than in the context of criminal prosecutions*”.⁽¹⁹⁾

This public interest role of the AG is neither particularly well known nor understood though it is potentially, including in the context of this present investigation, of great significance.

“ There shall be vested in the Attorney-General [...] the administration and business generally of public services in connection with the representation of the Government of Saorstát Eireann and of the public in all legal proceedings for the enforcement of law, the punishment of offenders and the assertion or protection of public rights and all powers, duties and functions connected with the same respectively, together with the duty of advising the Executive Council and the several Ministers in matters of law and of legal opinion.”

Ministers and Secretaries Act 1924, section 6(1)

Indeed, the then Chief Justice in 1994 referred to the public interest role as of far greater importance than the role of adviser to the Government. In welcoming the appointment of a new AG (Mr. Eoghan Fitzsimons S.C.), Chief Justice Liam Hamilton

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

“referred to the Attorney General’s responsibilities as legal adviser to the Government, but said these ‘paled into insignificance’ when compared with his role as ‘guardian of the public interest, the person who appropriately involves the jurisdiction of the High Court to protect the Constitution and the rights of the citizen as outlined in the Constitution’. “ (20)

Former Ombudsman, Kevin Murphy, has raised very interesting questions regarding the possibilities of this public interest role of the Attorney General. While accepting that there is little guidance available on how this public interest role should operate, he suggests that there is scope for the AG to act in circumstances where the State itself, or one of its emanations, is acting illegally. As Kevin Murphy put it (21):

“The public have a fundamental right to be protected against the State acting illegally. It is the AG’s responsibility to ensure that protection and, in a situation where a Minister or Government might refuse to stop breaching the law, there seems to be no barrier to the AG suing them at the instance of some members of the public.”

Mr. Murphy, writing in the aftermath of the Travers Report, instanced in particular “30 years of illegality” in the area of charging medical card holders for long-stay care.

It is clear, however, that the AG is in a difficult position in that the separate roles of legal adviser to the Government and guardian of the public interest will sometimes be in conflict. (22) This conflict has long been recognised. In 1995, the Oireachtas Select Committee on Finance and General Affairs produced a report on the Office of the Attorney General which, amongst other matters, drew attention to the inherent conflict between the two roles. The Select Committee put forward as a possible solution the creation of the new office of

Deputy Attorney General to which office might be delegated functions in situations of conflict of interest. Subsequently, this issue was considered in the 1996 *Report of the Constitution Review Group (CRG)* which, while it recognised the potential for conflict of interest, concluded that it did not require any particular action. The CRG Report estimated that the role of public interest guardian occupied, on average, just 5% of the AG’s time and this appears to have been a factor in the approach adopted by the Group. The CRG did, however, propose that where the AG perceived a conflict of interest to have arisen this could be dealt with by assigning the particular matter to a small panel of lawyers. In the event, the public interest role of the AG has not been dealt with and the situation remains as provided for in the Ministers and Secretaries Act 1924.

In the case of the litigation considered in this chapter, the AG is responsible, ultimately, for the conduct of the State’s defence of the actions. In this capacity, he may be aware of weaknesses in the State’s defence or even, perhaps, of wilful disregard over many years for the statutory rights of those in need of long-term care. In this type of situation, the separate roles are quite clearly incompatible.

Nevertheless, the function of guardian of the public interest has great potential by whomever the role may be exercised. In the present context, it would allow for a speedier, cheaper and less traumatic means of resolving an issue of rights which is relevant to a significant proportion of the population. The existence of an active guardian of the public interest (23) might also act as a deterrent to those within the State apparatus who are tempted to disregard the law - even where that temptation reflects what appears to be a good in itself, for example, the saving of scarce public resources. (24)

Notes

(1) In the wake of the Supreme Court judgment in re: *Article 26 and the Health (Amendment Bill)* 2005 IR 105, the Health Repayment Scheme was launched in August 2006 under the Health (Repayment Scheme) Act 2006. This Scheme provided for the repayment of maintenance charges paid by people who were residents of public nursing homes or who occupied public (contract) beds in private nursing homes in the period up to December 2004. According to the HSE, to date “in excess of 21,300 claims have been processed with determinations costing €437m.” (HSE submission to Ombudsman, 25 August 2010)

(2) But people placed by a health board in a so-called “contract bed” in a private nursing home are entitled to benefit under the Health Repayment Scheme.

(3) In her capacity as Information Commissioner, under the Freedom of Information Acts, the Ombudsman has frequently been before the Courts where her FOI decisions have been appealed. It is clear from the outcome of these appeals -where the Courts have upheld some appeals and dismissed others - that the status of the Ombudsman/ Information Commissioner has no bearing on the Courts’ judgments.

(4) These actions are being dealt with in open court and some details are available through the website of the Courts Service <http://www.courts.ie>. In addition, there has been some media reporting on the preliminary stages of individual cases - no case has yet gone to hearing. Ombudsman staff have attended at a number of motion for discovery hearings in the Master’s Court where the nature of the pleadings generally were disclosed. In addition, a certain level of general information has been emanating from Oireachtas debates and from some official reports.

(5) This decision, dated 7 July 2010, deals with three separate cases involving State parties as defendants: 1. *Cromane Seafoods Limited & Anor v the Minister for Agriculture, Fisheries and Food & Ors*; 2. *Edward Kelly v Galway County Council & Ors*; 3. *Stephen MacKenzie v the Health Service Executive & Ors*

(6) *The Irish Times* reported on 3 October 2007 that 407 legal actions had been initiated, inclusive of those in private nursing home care. In its *Annual Report and Financial Statements 2009*, (p. 115) the HSE noted that proceedings “have been instituted in 306 cases, involving patients who spent time in private nursing homes.” *The Irish Times* of 26 April 2010 reported that 340 sets of proceedings were

in place. In all likelihood, the vast majority of these cases concern people whose claims arise from having paid for private nursing home care and whose claims are not being granted under the Health Repayment Scheme.

(7) *In Re. Maud McInerney, A Ward of Court*, [1976 - 1977] ILRM 229

(8) In his 2001 report *Nursing Home Subventions*, the then Ombudsman took the view that the Health (In-Patient Services) Regulations 1993 were *ultra vires*.

“*Unjust enrichment*” - profit or gain unjustly obtained.

(Murdoch’s Dictionary of Irish Law)

“*Misfeasance in public office*” - held by the High Court in *Giles Kennedy v Law Society* (204) 1 ILRM 178 as consisting of a purported exercise of some power or authority otherwise than in an honest attempt to perform the functions of his office resulting in loss to the claimant (Murdoch’s Dictionary of Irish Law).

Some academic commentators have also suggested a potential restitution claim in the tort of misfeasance of public office. For example see Eoin O’Dell and Gerry Whyte in “Is this a Country for Old Men and Women - in Re Article 26 and the Health (Amendment) (No. 2) Bill 2004”, 2005, *Dublin University Law Journal*, 27

(9) Information provided by a HSE official in August 2009 before the HSE decided not to provide information and documentation relating to the litigation.

(10) The Separation of Powers and Constitutional Egalitarianism after the Health (Amendment) (No. 2) Bill Reference Oran Doyle and Gerry Whyte in *Older People in Modern Ireland – Essays on Law and Policy*, Eoin O’Dell (ed.) 2006

(11) The Travers Report (para. 3.11 - 3.12) recounts another interesting example of the apparent aversion of the Department and of the health boards to having health service law clarified by the Courts. In 1978 the Registrar of Wards of Court informed the health boards that, on the direction of the President of the High Court, he would not be paying any in-patient charges for long-stay patients (who were Wards of Court) with incomes of less than £25 per week. This was a higher threshold than applied to patients generally. The Registrar suggested that the issue be referred to the Courts. “*In the event, the invitation of the Registrar to the health boards and to the Department to challenge in the Courts the views and actions of the Registrar was not taken up.*”

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

(12) See Note 5 above.

(13) For example *Sinnott v Minister for Education* [2001] 2 IR 545, *T.D. v Minister for Education* [2001] 4 IR 259

(14) Mary Harney T.D., Minister for Health and Children, Dáil Éireann, Health (Amendment) Bill 2005 Second Stage debate, (3 March 2005)

(15) The action was settled in September 1996, shortly before her death, with a payment of £175,000 to Mrs McCole; it was subsequently reported that “her legal team’s bill came to over £800,000, while BSB lawyers earned £500,000” - *Irish Examiner*, (10 February 1998). The HSE points out that none of its predecessor health boards had any involvement in the McCole case.

(16) “Report by the Minister for Health and Children, Mr Brian Cowen, on the legal strategy adopted by the defence in the case of the late Mrs Bridget McCole”, as reported in *The Irish Times*, (2 August 1997)

(17) “The financial arguments are equally stark. To imply that in-patient services were demand-led and uncapped for the population (with full and limited eligibility) since 1970 has enormous financial implications, not just for the Department of Health but for the entirety of Government spending. It is difficult, if not impossible, to attempt to quantify the scenario whereby all of those eligible would have to be provided with in-patient services on demand over the past forty years. This would require not just attempting to extrapolate data for the full quantum of services and patients affected over those years, but also estimating what unmet need existed and stripping out the effect of private health insurance over that period.” Department’s Submission- Para 87

(18) Ministers and Secretaries Act 1924, section 6

(19) On the current website of the Attorney General, its Mission Statement makes no reference to the role as public interest guardian nor is there any easily identifiable reference to this role elsewhere on the website.

(20) Reported in the *Irish Times* of 16 November 1994

(21) “Fresh Look at Role of AG is Needed”, *Irish Times*, (11 July 2005)

(22) For a detailed account of these issues, see Darren Lehane “A Legal Janus: Resolving the Conflict Between the Attorney General’s Functions as Guardian of the Public Interest and Legal Adviser to the Government”, *Irish Student Law Review*, 2004 - Vol. 12. More recently, see Donncha O’Connell in *Village Magazine*, 8 June 2010.

(23) The Ombudsman is aware of a recent proposal from the Fine Gael party that a public interest function along these lines should be conferred on the Ombudsman. According to a footnote in its *New Politics* document “*Fine Gael will also examine whether some of the functions of the Attorney General, as they relate to his role as “guardian” of the public interest, should be transferred to the Ombudsman. We believe there is a potential conflict of interest between this function of the Attorney General and his other function as adviser to the Government*”. The comments in the final section of this chapter apply irrespective of who, in future, might exercise this public interest role.

(24) Another approach to this type of problem is suggested by Oran Doyle and Gerry Whyte, *op. cit.* They suggest that Irish law should recognise a *jus tertii* “that would enable a civic minded citizen or a pressure group to take a case enforcing the legal rights of a vulnerable section of the population where it is difficult for any individual member of that group to pursue such litigation. ...”.

9. CONCLUSIONS AND REFLECTIONS...

9. Conclusions and Reflections...

The conclusions of this investigation are easily stated :

- The Health Act 1970 has required the State ⁽¹⁾ to provide nursing home care for those who need it.
- It is an open question as to whether that obligation continues in place notwithstanding recent amendments to the Health Act 1970.
- The State has failed consistently to meet this obligation over four decades.
- The State has failed over that same period, and despite repeated commitments (especially since 2001), to amend the law so as to bring actual practice and legal obligations into harmony.
- Very many people over these decades have been deprived of their legal entitlement ⁽²⁾.
- Access to nursing home care over this period has been marked by confusion, uncertainty, misinformation, inconsistency and inequity.
- Very many people over this period have suffered significant adverse affect.
- This situation has been allowed continue with the full knowledge and consent of the responsible State agencies.
- Arising from these failures, the State is now facing several hundred legal actions from, or on behalf of, people seeking compensation for the costs incurred in having to avail of private nursing home care.
- These particular failures, which have been allowed continue for decades, point inevitably to wider failures in government.

At the administrative and institutional level, the continuation over such a long period of such unacceptable practices suggests inflexibility,

non-responsiveness and a reluctance to face reality. It also suggests, at times, a disregard for the law. As reflected in their failure to cooperate with the Ombudsman's investigation of these issues, the State agencies concerned have displayed intransigence, lack of transparency and accountability as well as a very poor sense of the public interest.

This unhappy state of affairs, as summarised above, has come about because of flaws in our system of government; flaws which allowed this situation to develop in the first place and flaws which, even after problems had been identified, have prevented matters being put to right. It is important to name these flaws in the hope that, once named, they might be addressed.

Ultimately, responsibility for changing the law is a matter for politicians and for the Oireachtas. But in our fused Executive/Legislature the reality is that the law is conceived, drafted and for all practical purposes determined by the Executive. This is acknowledged explicitly by the Department in its *Statement of Strategy 2009 - 2010*, where it defines its mandate as including: "To provide a legislative and regulatory framework that helps protect the interests of service users ...". There seems over the past 40 years to have been an enormous reluctance to recast the law on health entitlement. This failure to act has had knock-on consequences throughout the system. Continuing to act as if the law does not say what it actually says is not a solution.

The conduct of this investigation and the preparation of the Ombudsman's report for the Oireachtas have been marked by an unprecedented level of rancour and disagreement. The Department, in particular, has laid a multiplicity of charges against the Ombudsman regarding the manner in which the investigation has been conducted. Amongst its charges are:

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

- that the Ombudsman exceeded her jurisdiction in undertaking this investigation;
- that the Ombudsman failed to abide by fair procedures particularly in relation to the provision of a draft version of the investigation report;
- that the Ombudsman displayed prejudice and objective bias in the course of the investigation;
- that the Ombudsman displayed arrogance in purporting to interpret the law;
- that the Ombudsman has purported to deny the State bodies concerned their right to have the litigation (detailed in this report) determined by the Courts.

The Minister, acting on behalf of the Government, has informed the Ombudsman that the Government supports the submission of her Department in which these charges are made.

While the HSE, in general, has been more temperate, it has specifically charged the Ombudsman with attempting to influence the outcome of court proceedings. In effect, the Department and the HSE are saying that the Ombudsman undertook this investigation in bad faith.

This unprecedented opposition to an Ombudsman investigation appears to arise primarily - but not solely - from a deep-seated concern that any acceptance of the validity of the report's analysis could have enormous financial implications for the State. At a time when the State's finances are in crisis, this concern is understandable. The Ombudsman, however, believes that it is not sensible to withhold the analysis because the consequences of accepting its validity may be crippling in financial terms. The question of what redress should be provided for those who have been affected adversely is one which needs to be considered in the light of the circumstances in which we now find ourselves

as a country. Facing up to this problem, difficult as it may be, is far more constructive than denying that the problem exists.

For the record, the Ombudsman's motivation in producing this report was five-fold:

1. To highlight the very significant difficulties faced over several decades by families seeking to make arrangements for long-term nursing home care for a family member.
2. To represent, in many instances through their own words, the distress and upset (including financial) of people who complained to the Ombudsman's Office over the years in relation to nursing home care.
3. To highlight the inadequacy and the tardiness of the State's responses to these problems.
4. To raise the issue of whether and, if so how, people adversely affected should have some recognition of having been failed by the State.
5. To raise wider questions of governance prompted by the practices highlighted in this report.

The Ombudsman's criticisms of the Department and of the HSE are undoubtedly serious. These criticisms are not being made lightly; nor are they being made gratuitously. Nor are they intended to capitalise on the current popular mood which seeks to find fault with public bodies, especially in the health service, almost as a matter of principle. Nor are these criticisms directed against the majority of workers in the public health service who undoubtedly do their very best in difficult circumstances. The Ombudsman recognises that, of all policy areas, that of health care is particularly susceptible to ideological dispute, to interest group pressures, industrial relations difficulties and financial constraints.

In fact, this investigation represents the culmination of years of Ombudsman engagement with the issue of nursing home care for older people. While the content and conclusions of the investigation are undoubtedly informed by this engagement, the Ombudsman is satisfied that the investigation has been conducted fairly and reasonably. The Ombudsman has no desire to prolong the ill feeling which has characterised the exchanges with the Department and the HSE in the course of the investigation. Rather, she hopes that attention can now focus on the issues raised in the report. In particular, the Ombudsman hopes that within the Oireachtas there will be some reflection on what must be done to improve governance and to recognise the adverse consequences for those families which have been disadvantaged as a consequence of the practices dealt with in this report.

Dysfunctional Government?

The Ombudsman's report *Nursing Home Subventions*, presented to the Dáil and Seanad almost ten years ago, dealt with complaints of a slightly different flavour ⁽³⁾ but which, ultimately, have to do with the same fundamental problem. In fact, the equivalent chapter of that report ⁽⁴⁾ could, with only minor contextual amendments, be reproduced in full here. In that chapter, the then Ombudsman, Kevin Murphy, attempted to situate the immediate complaint issues in the wider context of a dysfunctional system of government. He identified, in particular, deficits in three sets of relationships which, in his view, contribute significantly to this dysfunction. These relationships are:

- **The relationship between the Oireachtas and the Executive** - the Constitutional model whereby the Legislature makes the laws and the Executive implements them has become a fiction; in fact, it is the Executive (Government) *"which decides policy;*

which proposes legislation and ensures its passage through the Oireachtas and, subsequently, in its executive capacity ensures that the laws are implemented."

Parliament is relatively powerless and not in a position to exercise the role (including that of calling the Executive to account) envisaged in the Constitution.

- **Relationships within the Executive**
 - in the past, there was a clear division of functions as between the political (Ministerial) side and the official side. The integrity of the governmental process depended, to a large extent, on the official side being seen to be non-political; the tension inevitably generated by this division was regarded as necessary and healthy. "Good government, as Professor Séamus Ó Cinnéide put it, *depended on a certain distance and balance between the two sides*". This distance and balance no longer applies and, again to quote Professor Ó Cinnéide, this change is part of *"an unspoken revolution in our system of governance"*. ⁽⁵⁾ Again, another key element in the overall model of government has been discarded or, at the very least, diluted considerably.

"In the long run, ... the disregard for clear principles of law, the sustained proffering of incorrect advice, the reluctance to acknowledge mistakes, the tardiness in the Department's dealings with the Ombudsman's Office - all of these can only undermine public confidence in government and in our democratic institutions and call into question whether the present arrangements facilitate efficient, open and accountable government."

Nursing Home Subventions- Report of the Ombudsman to the Dáil and Seanad, (January 2001), (p. 62)

“A question I have asked at least six times ... concerns whether the Government has examined the statutory entitlements of patients over 70 to free public or private nursing home care. If it transpires that people in this group have a statutory entitlement to nursing home care, it will make the illegal nursing home charges look like loose change. [...] Is this another problem that is brewing and will Deputies present in this House in 2009 hear Ministers claim that this issue was never raised with them? A serious problem exists in this area, which has not been addressed by the Tánaiste, even when questions were raised about it.”

Liam Twomey T.D., Dáil Éireann, (1 June 2006)

- **Relationship between Department and Health Boards** - similar to the relationships within the Executive, the relationship between the Department and the health boards is most effective where the latter are prepared to keep a certain distance from the former and to exercise, as necessary, their status as independent, statutory bodies. But the health boards, for the greater part, failed to act independently; to “a large extent, health boards appear to act in relation to the Department as if

“... asserted “governance flaws” or flaws in the way in which government operates are the subject of extensive comment by the Ombudsman in her draft report, as are her suggested “repairs” to governance structure. An investigation in relation to such matters is not properly a function of the Ombudsman under the 1980 Act. ... the Ombudsman is strictly limited by the provisions of the 1980 Act to the investigation of actions taken in the performance of administrative functions.”

Submission of Department of Health and Children
- response to Ombudsman draft report (23
August 2010)

they are satellites rather than independent bodies [...] The majority of the health boards were prepared to continue with a scheme, about which they increasingly had doubts, for as long as the Department told them they should.”

These observations of the then Ombudsman are, perhaps, even more pertinent now than when made almost ten years ago.

Oireachtas and the Executive

It is probable that this relationship has deteriorated rather than improved in the meantime. Reading Oireachtas Debates relating to health matters over the past ten years or so, one is struck by the extent to which Ministers appear to distrust the Dáil or Seanad as a forum in which to engage in anything like genuine debate on health issues. Very frequently, Ministerial contributions constitute set pieces or stock answers which have seen duty on many earlier occasions. A promise may be made, and repeated year in and year out, with no actual delivery on the promise. ⁽⁶⁾ Vital information may be withheld from the Dáil or Seanad even though it may be in circulation within the civil service or the wider public service. For example, legal advice concerning the illegal charging of patients for in-patient services was withheld from the Dáil and Seanad, and from the Committee on Health and Children, notwithstanding that it was in circulation within the health boards, the Department and, presumably, the Department of Finance. That advice was also made available to Mr. John Travers for the purposes of his report. All of this appears to have been based on a narrow legalism to do with the operation of legal privilege. Behaviour of this kind does little to suggest that the Executive actually displays the kind of respect for the Legislature, the representatives of the people, which is implicitly provided for in the Constitution.

On the specific issues at the heart of the litigation dealt with in Chapter 8, Opposition members have attempted to have these issues debated and have sought detailed information regarding the extent of the problem and regarding the position being adopted by the State. For the most part, these efforts have been unsuccessful. It is astonishing, and says much about the status of Parliament, that a Minister, or a Secretary General in the case of a Committee hearing, can quite blithely refuse such information on the grounds that disclosure might be detrimental to the conduct of the litigation.

It would be naive to pretend that this unhappy state of affairs is entirely the fault of the Executive of the day. All Governments in recent times have, to a greater or lesser extent, contributed to the present situation.

There are dangers inherent in allowing a system of government to proceed on the basis of what is a fiction. There are perhaps parallels here with what has been happening in the financial world in the US and Europe (including Ireland) in recent times. The governance systems for the large financial institutions appear to have been based on a fiction in which boards of directors purported to act in the interests of shareholders; in reality, boards and senior executives had learned to act in their own interests. This was facilitated by the fact that shareholders constituted large and widely dispersed groups often unable to act collectively or, quite simply, beset with inertia. In this scenario, the senior executives of financial institutions learned to regard shareholders as nuisances to be tolerated rather than an integral part of the governance arrangements on which the integrity of the financial system depended.⁽⁷⁾ Is it the same in Ireland in the case of the Executive and the Legislature? Does the Executive regard the Legislature as a nuisance to be tolerated rather than a vital cog in the overall machinery of government? The

“Whereas Dáil Éireann remains supreme in that it retains the ultimate power of making or breaking a Government, power actually resides with the Government rather than with the Oireachtas. [...] This means that the Dáil and Seanad find it very difficult to exercise any legislative or supervisory role other than what is permitted by the Government of the day. The main casualty in all of this is the integrity of the governmental process. As currently operated, the system of checks and balances envisaged in the Constitution appears not to be functioning. If it were functioning, it is unlikely that the difficulties with the nursing home subvention scheme (as described in this report) would ever have arisen.”

Nursing Home Subventions- Report of the Ombudsman to the Dáil and Seanad, (January 2001), (p. 65)

Ombudsman is not aware of any independent observer in recent decades who has expressed the view that the relationship between Executive and the Legislature is healthy and productive. In fact, most observers take the view that the opposite is the case.

“However, the Dáil does have a constitutional responsibility, within the ambit of domestic policy-making, to hold the Executive to account. The dominance of parties has made this increasingly difficult, especially when free votes, even on matters of conscience, are few and party whips dominate.

[...]

In the grand scheme of things, there should be a separation of powers, members would vote according to conscience, and the rights of the citizen would be protected against arbitrary action by an arrogant Executive. But that was designed for Virginian gentlemen like George Washington and Thomas Jefferson. Slave owners they might be, but nobody would order them how to vote.”

Maurice Hayes, Irish Independent (1 November 2010)

“In the intervening nine years [since publication of Nursing Home Subventions], unfortunately, the scale of the problem has increased rather than decreased. I do think, and again I say this with genuine deference to all the members of the Dáil and Seanad, that the situation is now so serious that it cannot continue to be ignored. It seems to me that a properly functioning parliament is even more necessary at times like these when, in effect, we have a national emergency on hands.”

Emily O’Reilly, Ombudsman - address to the Institute of Public Administration and Chartered Institute of Public Finance and Accounting Conference on Good Governance, (9 March 2010)

It is indisputably the case that our governmental arrangements are undermined significantly by virtue of having an Executive which is too powerful and a Legislature which is too weak.

Relationships within the Executive

What is at issue here is the balance which should exist between the political (Ministerial) side and the non-political (civil service) side. Clearly, this is a difficult balance to achieve and maintain. Inevitably, it involves some level of healthy tension between the two sides. As Accounting Officer, a Secretary General should

“The repeated statements made by Charlie McCreevy and his colleagues that the government, and not the civil servants, ran the country, showed either a lack of knowledge of the legal position or a disregard for it. The responsibility for safeguarding public funds and for the efficient administration of a government department lies not with the minister but with its secretary general, the head of the department.”

- Ed Walsh “Our system of governance assures a deficit of talent”, *Irish Times* (6 July 2010)

be in a position to exercise considerable control within his or her Department and, it would appear, is intended to act as a counter-weight to the more political inclinations of the Minister of the day.⁽⁸⁾

There is a view that in previous decades a reasonable balance was maintained and that this was helped considerably by the insistence of strong senior civil servants that a certain distance be maintained from the Minister of the day. The question must be asked whether in more recent times this balance has suffered and whether, in fact, senior civil servants have maintained a sufficient distance from the political side. The fact that Ministers now bring their own advisers with them into Departments, and the fact that Ministers operate substantial constituency offices staffed by their Departments, must have a bearing on the political/administrative balance.

In the recent past, relationships within the Department came under intense scrutiny in a very public way. The focus of this scrutiny was on whether or not the then Minister had been briefed by his Secretary General on a legal issue and whether, subsequently, the successor Minister was given accurate information on events relating to the state of knowledge, within the Department, concerning that legal issue. The legal issue was that the health boards had, for decades, been charging medical card holders for in-patient services despite having been warned by several different legal advisers that the practice was illegal. The situation within the Department appears to have been complicated by the fact that the Minister had brought in a number of external advisers and there appeared to be some confusion regarding internal channels of communication as a consequence.⁽⁹⁾

One of the key conclusions of this present report is that a significant problem, regarding the right of older people to be provided with long-term nursing home care, has remained

unresolved for many years. Leaving to one side the plight of those families whose rights were not being vindicated, this issue has constituted a high level risk ⁽¹⁰⁾ in the sense that there was the prospect always of litigation and of the State being exposed to considerable costs in compensation - as has happened already with the Health Repayment Scheme. Indeed, even if the Courts were to find ultimately that there is not an enforceable right to long-stay nursing home care, the fact that litigation was a likelihood was a risk to be avoided. The Executive, in the form of the Department, has failed to deal with the problem and the question must be asked: why? In the absence of hard information, one can only speculate as to the reasons for this failure. In fact, we know almost nothing of whatever discussions may have taken place, or whatever proposals may have been made, within the Department in relation to this problem. It may be the case that within the Department there has long been an awareness of this risk but that the legislative measures needed to deal with it were politically unpalatable. If this were to be the case, it would suggest a worrying level of dysfunction within the Department.

The question of balance may also arise in the manner in which the NHSS is being promoted by the Department (and the HSE) as the “Fair Deal” Scheme. The Department’s information material on the NHSS refers to it as the “Fair Deal” Scheme and amongst the public generally this is the title by which it is known. There has been a very successful marketing campaign to “sell” the NHSS under the “Fair Deal” label. The term itself, presumably, is intended to echo the “Fair Deal” reform programme of US President Truman from the late 1940s. In the USA, where the Executive is openly political, it is not unusual to promote official schemes in a political fashion. This has not been the case in Ireland where it is not usual to promote State schemes using the language of marketing and political spin.

“The Government does indeed “run the country”, but not without some constraints. The system of accountability established by the Mullarkey group included the requirement that assessments be carried out of the “strategic, operational, financial and reputational” risks of policies. The system also provided senior officials with instruments to contest what they consider to be political decisions that lack “integrity”, “regularity”, or “propriety”. In such cases, they can insist on receiving the Minister’s instructions in writing and on receipt of the written instructions they immediately send the papers to the CAG.”

- Eddie Molloy “Seven things the public service needs to do”, Irish Times (9 April 2010)

Thus, for example, the Civil Legal Aid Scheme is not promoted as “Justice for All” nor is Child Benefit promoted as “Cherish the Child”. In so far as there may be some “spin” involved with the “Fair Deal” slogan, one might reasonably ask if it is intended to distract attention from some related difficult issues. For example, while people generally may now be aware that there is a new set of arrangements in place under which the State will subsidise

“The Department [of Health & Children] categorises its principal customers and stakeholders into three broad groups:

- *the Minister, the Ministers of State and the Oireachtas;*
- *the HSE and other health sector agencies;*
- *the public (as health service users, taxpayers and citizens).*

However, in reality, the strong perception exists amongst the Department’s staff, its agencies and its stakeholders that the Department’s actions demonstrate that it pays most attention to two groups of customers: pre-eminently to the Ministers and the Oireachtas, but also to the professional representative bodies. This disparity ... is a source of real frustration to many of the Department’s staff, customers and stakeholders.”

Second Report of the Organisation Review Programme, Department of the Taoiseach, 2010

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

older people needing long-term nursing home care, very few appear to be aware that one of the consequences of the NHSS Act (as the Department sees it) has been to remove the obligation on the State to provide such care. The “Fair Deal” marketing emphasises the former and omits the latter.

The comments above have no bearing on the making of law by the Oireachtas. Rather, the question being raised is whether senior civil servants should participate in the promotion of a statutory scheme in a style which could be seen as both partial and politically motivated. If senior civil servants were to be perceived as acting politically this would tend to undermine the model on which our government is based. If it is no longer realistic to expect senior civil servants to behave in the formal, correct and rather austere fashion which characterised the civil service of decades back, then it might be better to acknowledge this and to change the model. In some other countries it is relatively usual that the senior people in a government Department come and go with the Minister of the day.

The Department has been the subject of review recently under the Organisational Review Programme (ORP), a public service modernisation initiative, under the auspices of the Department of the Taoiseach. The ORP is predicated on the view that, while the Irish public service has been in reform mode for some time now, it “needs to move to the next point on the reform trajectory and become more outward focused, especially in adopting integrated or system wide responses to new challenges and needs”.⁽¹¹⁾ In its report on the Department⁽¹²⁾, and under the heading “Serving the democratic process”, the ORP draws attention to the very significant demands placed on the Department in dealing with what it characterises as “political work (for example, Parliamentary Questions, TD’s representations, Dáil and Seanad adjournment

debates, questions on the Order of Business, speeches, serving Oireachtas Committees, etc.).” The report goes on to observe that the “overwhelming priority attached to serving Ministers, Ministers of State and the Oireachtas results in very significant resources within the Department being devoted to this work”; the report then observes that “[m]any staff, agencies and stakeholders believe that the Department should strike a better balance between its servicing of the democratic process and the needs of its other customers and stakeholders.” The report notes that other organisations which have achieved such a better balance have “fundamentally changed their organisational structures so as to explicitly orientate their focus towards serving the needs of their customers and, as well as this [have] aligned their staff, their processes and their procedures accordingly”.

The ORP report does not address directly the extent to which the Department’s “political work” is designed to support the actions of its Minister and Ministers of State - as opposed to constituting a neutral service to the Oireachtas and its members. Nevertheless, the report conveys a clear message that the Department has got the balance wrong and that the extent of the “political work” undermines the wider functions of the Department. In fairness to the Department, and as the ORP report acknowledges, the health area is fraught “with significant strategic, policy and management challenges”. Politically, the health portfolio has long been regarded as something of a “poisoned chalice”. Nevertheless, it seems clear that the Department is focused inwards to an excessive extent and that more needs to be done to achieve a healthier balance between the political (Ministerial) side and the non-political (civil service) side.

Relationship between the Department and Health Boards (HSE)

The establishment of the HSE, the definition of its functions and powers, and the nature of its relationship with the Minister and the Department, are provided for in the Health Act 2004. The general expectation with the establishment of the HSE was that, while it would bring greater coherence and consistency to health service delivery and give better value for money, it would also operate at arms length from the political system. There was an expectation that the HSE would be independent in the manner in which it delivered services and in the choices it would make as between services (subject to statutory obligations); and all of this would be within the context that overall health policy would continue to be set by the Minister and the Government. In fact, in terms of the relationship between the HSE and the Minister/Department, the situation is not always clear-cut. The Department acknowledges this to be the case. In its recently published Action Plan in response to the ORP report, the Department notes the extent to which it and the HSE must work together; however, it also notes “a need to delineate better the Department’s distinctive roles and functions, to communicate how they differ from those of the HSE and other agencies within the health sector, and to ensure that in future we focus more on the delivery of those distinctive functions.” ⁽¹³⁾

It is unfortunate, almost six years after the HSE’s establishment, that there should continue to be confusion regarding the respective roles of the HSE and of the Department. It has been suggested by some commentators (see opposite), despite the many years of consultation and preparation, that the establishment of the HSE ultimately was rushed and that the legislation underpinning it is inadequate. In particular, it is argued that

the division of responsibility between the Minister and the HSE, as between policy and operations, is confused and uncertain. Yet while the Health Act 2004 is generally non-specific in how it deals with the respective roles of the HSE and the Minister, it does provide that the Minister may direct the HSE to take certain actions and the HSE is required to implement these actions. ⁽¹⁴⁾ It seems the Minister rarely invokes this power to direct but that the existence of the right to issue directions conditions the relationship between the HSE and the Department to the extent that the Department sees it as the role of the HSE “to implement and to operationalise the policy” of the Department. ⁽¹⁵⁾

The extent of the confusion regarding the respective roles of the Department and of the HSE is reflected in the recently-published ORP report on the Department:

“The way the Health Act 2004 was dealt with by the Oireachtas is an example of how not to enact legislation. The Oireachtas did not properly consider or debate the legislation which became the Health Act 2004. In the Dáil, there were two days of Committee Stage discussions. This is the stage during which legislation should be minutely examined and amended if necessary. There were 169 amendments discussed at Committee Stage. At Report Stage, there were a total of 151 amendments due for discussion. When Amendment No. 12 had been reached, the process was guillotined. The majority of the amendments were being proposed by the Government. Opposition deputies complained that they had only received some of these amendments the night before and some on the day of the Report Stage. It is hardly surprising that poor quality legislation is passed when practices such as these are allowed to continue.”

Ita Mangan, in *Older People in Modern Ireland - Essays on Law and Policy*, Eoin O’Dell (ed)

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

“The Department’s staff, its agencies and its stakeholders expressed the strong view that, as a priority, the Department must do a lot more to fully clarify the respective roles and responsibilities of the Department and of the HSE. The high level definition is clear enough: the Department is responsible for policy, and the HSE is responsible for delivery. However, in practice there are significant tensions between both organisations around this boundary line, and a central question that needs to be answered is ‘where does policy stop and the operational begin?’. Staff at all levels in the Department and in the HSE want the ambiguity around the detail of these organisation’s respective roles and responsibilities to be fully clarified.” (16)

The experience of the Ombudsman arising from this investigation is that the HSE has not brought any fresh thinking to the issue of its obligations to provide nursing home care for older people. Insofar as there are legal obligations regarding provision of nursing home care, those obligations are placed, in law, on the shoulders of the HSE (health boards). The Ombudsman accepts that, in the past, health boards (HSE) did not have the resources to meet the demand for long-stay care imposed by section 52 of the Health Act 1970. The HSE itself now says that, because of the requirement to operate within resources, it did not have the capacity to meet this demand. What one could reasonably expect the health boards (HSE) to have done was to inform the Department that it was unable to meet its statutory obligations within the resources allocated and to explain to the public why it was not able to meet its obligations. While we do not know what the health boards (HSE) may have said to the Department, we do know that they never acknowledged publicly that older people had the right to long-stay care and they never explained publicly the reasons why these rights were not being honoured. In this sense, the failure of the health boards (HSE) has been one

of a lack of transparency in failing to explain its dilemma publicly.

Many of the problems in the health area stem from having a legislative framework for entitlement which requires provision at a level which, for whatever reason (resources or structures or both), the State has frequently failed to honour. The rights of those who need long-stay nursing home care is a prime example of this situation. One can understand the difficulties facing HSE managers attempting to meet statutory obligations without, in some cases, having the requisite resources and structures to do so. However, adopting the approach that the law does not create rights for the public is wrong and counterproductive. It would be much more productive, and certainly more likely to produce a reasonable and legally correct outcome, were the HSE to acknowledge its difficulty and put the finding of a solution into the public and political domains. This approach would require the exercise by the HSE of a degree of independence which the health boards, in the past, certainly did not display.

Historically, the relationship between the health boards and the Department was one in which the former had learned generally not to act without the permission of the latter. At several points over the long history of the illegal charging of long-stay patients, and in the related area of the operation of the nursing home subvention scheme, various health boards had strong legal advice that their actions were illegal. For the most part, the health boards failed to act on this advice until they were “allowed” to do so by the Department; this, as we know, did not happen in several instances until very late in the day. Had the health boards sufficient courage to act in their own right in relation to their own legal obligations then much of the chaos described in this report would have been avoided. It would have been far more productive, and

possibly have led to a resolution of the problem many years ago, had the health boards (HSE) acknowledged that, while they were obliged to provide nursing home care, they did not have sufficient funding to meet their obligations.

There is some evidence in recent times that the HSE is willing to act independently and with greater transparency. On the independence front, though the particular example may seem perverse, there was the recent episode in which the HSE refused to provide the Minister for Children and Youth Affairs with the details of children who had died while in the care of the HSE. ⁽¹⁷⁾ On the transparency front, the current HSE practice of publishing monthly Performance Reports on its website is a decided step forward. In this regard, also, the HSE is currently quite open in saying that the necessity to curtail services in some parts of the country (in particular, in the West) is a direct consequence of budget overruns and the non-availability of additional funding. Had this type of direct and transparent approach been adopted in relation to the nursing home issue in the past, in all likelihood the legal issues would have been identified and dealt with years ago.

Findings and Proposals

Arising from this investigation, the Ombudsman proposes actions on two fronts: (a) in the specific context of those whose right to long-stay care has not been met and who have incurred costs as a result, and (b) action to make it less likely in future that issues regarding the rights of defined groups will remain unresolved for long periods.

Specific Issue

In the normal course, an Ombudsman investigation includes findings or conclusions and (where relevant) recommendations to the public body concerned that redress be provided to the parties adversely affected. In the present case the Ombudsman finds, in relation to the type of complaints dealt with

in this investigation, that the health boards (HSE) failed to fulfil their obligations to older people under section 52 of the Health Act 1970 and that this failure came about with the full knowledge and agreement of the Department. As a result of these failures, very many older people (and their families) suffered significant adverse affect over several decades. The Ombudsman finds that these failures of the health boards (HSE) and of the Department constitute (to use the language of the Ombudsman Act) actions “*based on an undesirable administrative practice*” and also actions “*contrary to fair or sound administration*”.

These findings are at a level of generality as this investigation is an “own initiative” one rather than one linked to specific, named complainants.

The Ombudsman takes the view that the HSE and the Department should acknowledge formally that the State, in the case of older people needing long-term nursing home care, has not been meeting its obligations under section 52 of the Health Act 1970. This acknowledgment could be in the form of a public statement from the two bodies and could be made on a “without prejudice” basis.

There is no satisfactory solution to the issue of whether there should be financial redress for those who have been adversely affected by the State’s failure to provide long-stay care. The financial consequences for the State, in meeting a recommendation to compensate all those adversely affected, would be enormous, potentially running to several billion euro.

In present circumstances, it appears this is not a cost which the State can meet. Nor is it likely that the State will be in a position to meet this type of charge for many years to come. On the other hand, not to recommend financial redress, might be seen as condoning maladministration and allowing bad practice

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

to go unchecked. It would also mean that individual people and their families are being left with nowhere to turn and with a financial burden to bear which, as the Ombudsman understands the law, should have been borne by the State.

With considerable reluctance, the Ombudsman takes the view that in present circumstances the public interest is best served in not recommending any specific redress in the sense of financial compensation for those affected adversely. At the same time, where financial redress is not being recommended, it is even more important that the State recognises and acknowledges its failures in not providing long-stay care to all of those who needed such care.

The Ombudsman suggests that some thought be given within the Department to devising some limited scheme under which families which have suffered serious financial hardship might be assisted. In making this suggestion, the Ombudsman appreciates that any such scheme would be fraught with difficulties and might well require legislative underpinning. One possibility in this regard is that the existing Supplementary Welfare Allowance scheme might provide the statutory mechanism for the making of one-off payments, based on exceptional need, for such people affected adversely by the State's failure to provide nursing home care for a family member. In any event, the Ombudsman recognises that such a scheme, providing limited redress, could not displace the existing right of an affected person to take legal action to seek compensation. However, the Ombudsman believes that the vast majority of affected persons would welcome a solution which avoids the necessity to go to court.

Wider Issue

The more general proposal is intended to prevent situations, such as described in this report, coming about in the future; or, where

they do come about, the intention is that they would be dealt with at the earliest possible stage. A key element in this proposal is that, in future, measures to deal with such instances should be conducted with full transparency and in the public domain. The Ombudsman proposes the creation of an independent group whose function would be to advise Government on how best to handle legal actions, or threatened legal actions, which involve numbers of people and which arise from a contended failure of a State agency to meet statutory obligations particularly in instances where those claimed to be affected belong to a vulnerable group in society. Past examples of situations where such an approach might have been helpful include: the army deafness claims, the contaminated blood claims, education rights of autistic children, provision of secure care for children and the right of older people to long-stay nursing home care.

This proposal is based on the premise that the State should react to such situations, not simply in legalistic terms, but in terms which have regard both to legal rights (including human rights), to the State's finances and the overall public interest. The proposal envisages that, while ultimate legal responsibility for dealing with such claims will continue to rest with the State (and its relevant agency), the direction of the State's response should have regard to the advice of this group. Amongst the options for this group would be that of stating a case to the High Court, perhaps at an early stage, in order to get legal clarity where that is needed. The overall thrust of this proposal is that the State's response to situations of this kind should be speedy, be made at an early stage, and be based on considerations of fairness and the public good rather than, as tends to happen at present, being defensive, combative and legalistic.

Some thought might be given to the possibility of such a group acting as adviser to the

Attorney General in fulfilling the role of guardian of the public interest or, alternatively, that this group would replace the Attorney General in fulfilling that role. In any case, there is certainly considerable scope for improving our governmental mechanisms with a view to ensuring that, where these major issues arise, they will be handled always with a view to securing the public interest.

Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland

Notes

(1) References to “the State” or its agencies are references primarily to the Department and to the HSE (including the health boards prior to 2005).

(2) We make no attempt in this report to estimate the numbers affected.

(3) That report dealt primarily with the operation of the system of nursing home subventions provided for in the Health (Nursing Homes) Act 1990. However, the Ombudsman made clear then his view that the Health Act 1970 conferred a right to be provided with nursing home care as an aspect of “in-patient services”. For example: *“The Ombudsman does not accept that there is any doubt as to the obligation on health boards to provide in-patient services for eligible people. This is clearly established by Section 52(1) of the Health Act, 1970”* p. 14, Note 1.

(4) Chapter 8 of *Nursing Home Subventions* - Report of the Ombudsman to the Dáil and Seanad, (January 2001)

(5) Séamus Ó Cinnéide, “Democracy and the Constitution”, Administration, 1999 Vol. 46 (4)

(6) See, for example, Chapter 6 and the succession of promises to introduce new legislation governing eligibility for health services.

(7) *“The traditional notion of corporate governance exercised by a board of directors, acting in the interests of the stockholders, has long been a fiction for many firms. [...] ... shareowners have become in management’s eyes merely another source of funding: like the firm’s bondholders, but more of a nuisance.”* Benjamin M. Friedman, “Two Roads to Our Financial Catastrophe” in *The New York Review of Books*, 29 April 2010

(8) This issue attracts sporadic attention in the media, for example: *“The net effect of senior public servants carrying out political instructions that they know to contain unacceptable risk, or that they deem to be improper, is that these officials have failed in their duty to the public. To the degree that this is the road they have taken, then they have chosen to place the political needs of the incumbent government ahead of the public good. They have become politicised. In saying this, I am well aware that we live in a democracy and that the Civil Service is obliged to carry out the instructions of the elected government. However, in other democracies there is more “distance” between ministers and their officials. This issue, the need to reconcile the*

prerogatives of ministers with the duty of civil servants to act ultimately in the public interest – “speaking truth to power” – is a matter of fundamental importance. Other countries have managed to get the balance right and we need to learn from them.” “Seven things the public service needs to do” - Eddie Molloy, Irish Times (9 April 2010)

(9) These events were the subject of the Travers Report.

(10) The Department appears not to have published any details of its risk register and risk management practices.

(11) *Report of the Organisational Review Programme (Pilot Phase)*, November 2008 - <http://www.orp.ie/eng/Publications/>

(12) *Second Report of the Organisational Review Programme*, September 2010 - <http://www.orp.ie/eng/Publications/>

(13) The Secretary General of the Department had previously acknowledged this confusion in a statement to the Dáil Committee of Public Accounts on 7 May 2009: *“Understandably, there remains some confusion about the respective roles of the Department and the HSE. Our ultimate customers are the same - the people who need and use the Irish health care system - and we work together on a daily basis to try to ensure that the best possible services are provided to the people of Ireland”*.

Oddly, in its submission (Para. 48) on the draft of this report, the Department expressed the opposite view: *“There is no lack of clarity in relation to the relationship between the Minister and the HSE... It is extraordinary that the Ombudsman would purport to make such broad and misplaced statements without any evidential basis for them,”*

(14) Health Act 2004, section 10

(15) Interview with Departmental officials, (9 July 2009) (prior to notification of this investigation).

(16) *Second Report of the Organisational Review Programme*, September 2010 - <http://www.orp.ie/eng/Publications/>

(17) The HSE refused to provide child care records for the purposes of the inquiry being conducted into the deaths of children while in HSE care. This inquiry is being conducted on behalf of the Department by Ms. Norah Gibbons and Mr. Geoffrey Shannon. Arising from this situation, the Minister for Health and Children brought the Health (Amendment) Bill 2010 before the Oireachtas in June of this year. This Bill was given priority in the Dáil and Seanad and was signed into law, as the Health (Amendment) Act 2010, by the President on 3 July 2010.