

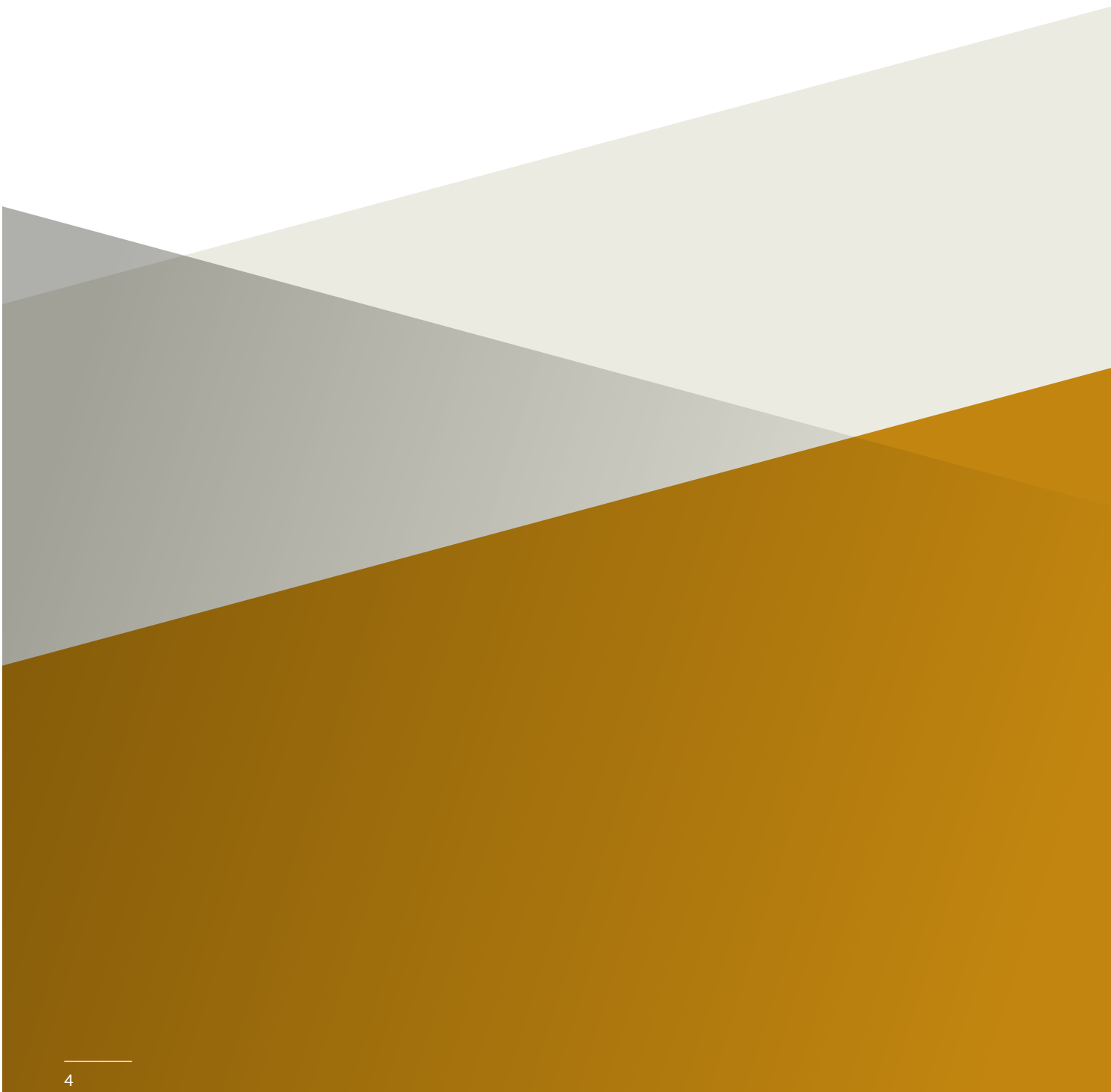
**Report of the Independent Review
Group established to examine the role of
voluntary organisations in publicly funded
health and personal social services**



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1 Introductory remarks and mandate

1.1 Foreword

The Minister for Health established an Independent Review Group (IRG) in August 2017 to examine the role of voluntary organisations in the provision of health and personal social services and to make recommendations on the future evolution of their role. Today's system has developed over many years, often in response to changes on the ground and in society. The publication of the Sláintecare report¹ in 2017 and of the Sláintecare Implementation Strategy² in August 2018 mark a new stage in designing a national vision for our health and social care system and mean that further changes are to come. Our recommendations should therefore be seen as a contribution to a process of transition and evolution over the coming years.

Ireland owes a debt of gratitude to all of those who work in the voluntary sector. Historically, it was the first to provide hospital and social care to the poor and most vulnerable in Irish society. Voluntary organisations, often originating in religious and charitable bodies, offered care at a time when the State did not. The sector has grown from that historical basis to provide approximately one quarter of acute hospital services³ and approximately two thirds of services to people with disabilities⁴. Thus, the delivery of many of our health and social care services today is dependent on voluntary organisations, which form an essential and integral part of the overall system.

One of the key principles guiding our approach was to listen to all views and to build an evidence base for our findings and recommendations. In the course of this review, we met with many dedicated people from the voluntary sector who work and advocate on behalf of service users. We also met many highly committed staff who work in the public sector and who demonstrate similar dedication. We are grateful to all of them for sharing their expertise, their ideas and, sometimes, their frustrations with us. We were struck by their need to be listened to and by their willingness to find a new basis for co-operation.

In addition to over 40 stakeholder meetings⁵ and the many written inputs we received, we conducted a public consultation process to seek views on the role of the voluntary sector. We received 102 responses to the consultation questionnaire, and a further 11 submissions⁶. Our thinking was also informed by research conducted by the Health Research Board (HRB) on the governance of voluntary health and social care providers in England and Ontario⁷, and by a meeting with experts from Portugal, France, Belgium and Germany facilitated by the European Observatory on Health Systems and Policies to discuss issues of relevance to our work.

Our work over the past year has led us to conclude that Ireland benefits from a strong public service commitment in both the statutory and voluntary sectors. Our remit specifically asked us to examine the role of voluntary organisations. We identified the following areas in which the sector provides added value:

- Leadership, innovation, flexibility, responsiveness and local community involvement in health and social care – a sector that affects all citizens at some time in their lives and, for some, for all of their lives;

1 Houses of the Oireachtas Committee on the Future of Healthcare, Sláintecare Report, May 2017.

2 Sláintecare Implementation Strategy, Department of Health, August 2018.

3 Voluntary hospitals account for 28% of in-patient beds in publicly funded acute hospital care according to HSE Business Intelligence Unit data. According to HIPE data, in 2017 voluntary hospitals accounted for 26% of in-patient discharges from publicly funded acute hospitals.

4 As estimated by the National Disability Authority in its submission to the Independent Review Group.

5 See Appendix 1 for further details.

6 See report in 2018 Consultations, www.health.gov.ie/consultations.

7 Joan Quigley and Jean Long, *Governance of voluntary health and social care providers – England and Canada*, Health Research Board, 2018.

- Capacity to make decisions close to the service provided and benefitting from the personal involvement of volunteers who give their time and expertise freely for the well-being of their fellow citizens;
- A long tradition of advocacy on behalf of service users and an important role in influencing public policy.

There is also a growing realisation in recent years that health and social care funding needs to move away from a focus on providers towards a greater focus on the services needed by individuals and the overall population. We note that the Sláintecare Implementation Strategy puts great emphasis on delivering care in the community, close to where people live, and this in our view is one of the strengths of the voluntary sector. Indeed, this is a trend that can also be seen in other countries.

For these reasons and in order to preserve the positive impacts of the voluntary sector into the future, it is important that the sector is included in future developments, including licensing and commissioning. Good policy development in health and social care relies on learning from the experience of those who work within it.

If the voluntary sector is to be retained, as we believe it should, there is a need to give public recognition to its legally separate nature and at the same time enable it to work more closely and effectively with the statutory system. We concluded that this will require a re-setting of the relationship between the State and the voluntary sector. The challenge is to find an appropriate balance between the necessary control by the State over policy and funding, and the autonomy and independence of the voluntary sector. This would ensure that the voluntary sector can continue to deliver agreed services to nationally determined standards of care in ways that enable it to play to its strengths. The voluntary sector must also recognise that its dependence on the State for a large proportion of its annual funding means it cannot work in isolation but rather must co-operate fully in delivering national health and social care strategies and must demonstrate compliance with best practice in terms of governance, quality, safety and financial probity.

As part of our mandate we analysed the involvement of faith-based organisations in the sector and examined whether their faith-based ethos affects the availability and delivery of publicly funded health and social care services. We also discussed the State's obligation to organise its health and social care services to ensure access to lawful services by all its citizens, and the obligation on health and social care organisations to comply with Irish law irrespective of their religious affiliation.

The work of our group was limited in time but we consider that we have been able to fulfil our mandate to provide information on the voluntary sector and to make recommendations that can support a new partnership between it and the public sector. We believe that many of our recommendations fit with the policy direction outlined in the Sláintecare Implementation Strategy and can help to deliver on its ambition.

We would like to thank the secretariat in the Department of Health (Sarah Rose Flynn and Colm Solan) who supported our work tirelessly and very effectively.



Catherine Day
Catherine Day
(Chairperson)



Jane B. Grimson
Jane Grimson

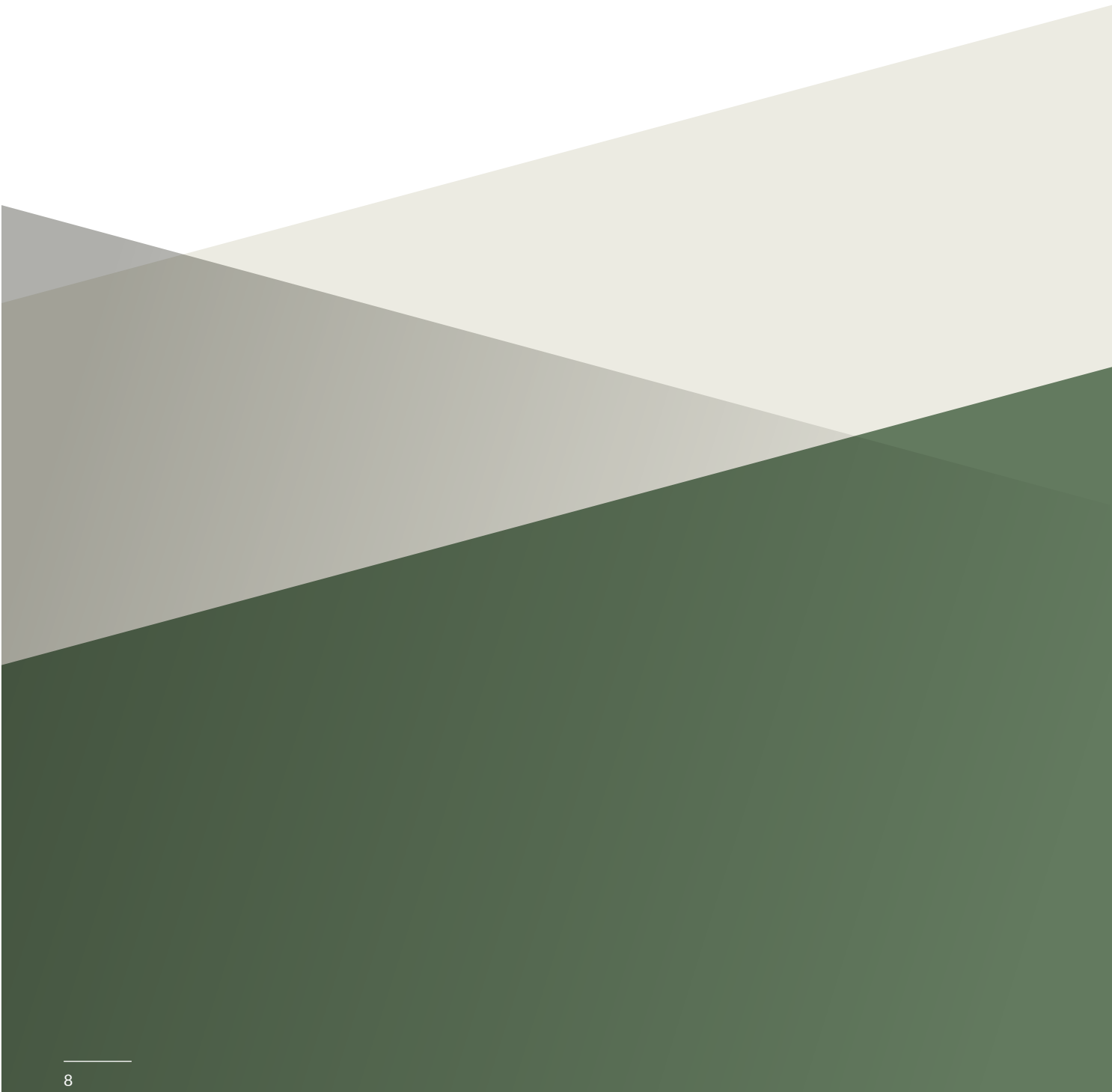


Deirdre Madden
Deirdre Madden

1.2 Terms of reference

The Review Group shall examine and inquire into the current role and status of voluntary organisations in the operation of health and personal social services in Ireland, including religious and faith-based organisations, the strengths and weaknesses of this mode of service provision, the issues which arise in connection with the provision of services to the public through such organisations, and to make recommendations on how the relationship between the State and voluntary organisations in the arena of health and personal social services should evolve in the future. In particular, the Review Group shall

- Examine and inquire into the role played by voluntary organisations in the provision of health and personal social services in Ireland including the contribution such organisations have made and continue to make to the Irish health service;
- Seek views and consult with service providers, service users, the public, funders, regulators, and other interested parties;
- Provide a factual report with an overview of the different types of legal status and governance structures of health and personal social service providers which are owned, managed or governed by voluntary organisations, with more detailed factual information on the major acute hospitals and such other major providers as the Review Group may deem appropriate;
- Outline the issues which, in the view of the Review Group, arise at present from the model of providing services to the public in the area of health and social care through voluntary organisations, and any particular issues arising in connection with providing services through religious or faith-based organisations, having particular regard to the availability of publicly funded health services, equality considerations, patient safety, value-for-money, clinical governance, education and training of healthcare professionals, performance oversight, protection of public capital investment and risk management;
- Outline the issues which, in the view of the Review Group are likely to arise in the future from this model, having regard to changing patterns of religious affiliation in the population, changes in the organisations providing such services (including declining vocations to religious life), possible changes in the configuration of services, and possible future requirements for hospital amalgamation or co-location;
- Make recommendations to the Minister for Health on the principles which should inform the future relationship between the State and voluntary service providers; and
- Suggest options to the Minister for actions that would enhance the delivery of services and safeguard public investment, particularly where large capital investments are required or where withdrawal of services is being considered.



2 Executive summary and recommendations

2.1 Executive summary

The voluntary sector is composed of a wide range of organisations that vary significantly in terms of size, geographical coverage and the type of services provided. In this context the main finding in this Report is the clear need for the statutory and the voluntary sectors to recognise that they depend upon and benefit from each other. An intertwined and complex relationship has existed between the two sectors for many years during which time there has been mixed success in terms of co-operation at local and national levels. In many instances, strong and effective local relationships ensured the provision of services, sharing of learning, and collaboration on quality improvement measures. However, in other instances, particularly at national level, this relationship has become strained, especially during the recent financial crisis and the rapid succession of different proposals for structural reform. We recognise the debt of gratitude that Ireland owes to the voluntary sector and consider that it is necessary to put the ongoing relationship between the State and the voluntary sector on a clearly defined basis, in keeping with the expectations of our citizens.

Our mandate requested a mix of analysis and identification of issues to be accompanied by recommendations to the Minister. We have analysed the extent of State dependence on the voluntary sector and found that it accounts for approximately one quarter of publicly funded acute hospital care⁸. The voluntary sector also provides around two thirds of disability services⁹. The State paid the voluntary sector approximately €3.3 billion for services delivered in 2017, representing just under a quarter of the Health Service Executive (HSE) budget in that year¹⁰. This demonstrates a very significant mutual reliance – by the State on voluntary organisations for delivery of services and by voluntary organisations on the State for funding. This must be taken into account in any discussion on the role of the voluntary sector.

The current mix of public, voluntary and private health care organisations is not unique to Ireland. We found it useful to examine the situation in a number of other countries with similar historical developments in their health and social care services. We have seen how they have successfully navigated similar paths and we believe we can learn from their experiences. In particular, we noted that voluntary organisations are recognised both for the value they bring to the healthcare systems in those countries and also as forming an integral part of those systems.

We examined the ownership structures of the largest voluntary organisations and looked at the governance and control of their Boards. We found a diversity and complexity of structures, some of which have existed for centuries, and others which have undergone a more modern revision. While wishing to respect the provenance and history of these organisations, we are also mindful of the need to provide assurances that public funding is appropriately accounted for and that all publicly funded organisations are compliant with sound financial practice, good corporate governance and meet the needs and expectations of the public in respect of the type and quality of services provided.

8 Voluntary hospitals account for 28% of beds in publicly funded acute hospital care according to Hospital In-Patient Enquiry (HIPE) data. In 2017, voluntary hospitals accounted for 26% of in-patient discharges from publicly funded acute hospitals. Note: For the purpose of this report we have not included St. James's Hospital or Beaumont Hospital Dublin as voluntary hospitals – both are State-owned and their Board members are appointed by the Minister for Health, thus distinguishing them from voluntary acute hospitals.

9 As estimated by the National Disability Authority in its submission to the Independent Review Group.

10 Derived from HSE Annual Report and Financial Statements 2017, available at <https://www.hse.ie/eng/services/publications/corporate/hse-annual-report-and-financial-statements-2017-pdf.pdf>.

We analysed the potential consequences of a winding-up of these organisations to ascertain the answer to difficult questions around the disposal of assets and proceeds of sale. These are complex issues which are determined by a mix of company law, charities law and for some organisations are also influenced internally by canon law. Our aim in examining this issue was to establish who actually owns the organisations, including faith-based organisations, and to ascertain, as far as possible, the extent to which the capital investment granted by the State to these organisations over a period of many years is protected in the event of a winding-up.

Our mandate asked us to consider *“any particular issues arising in connection with providing services through religious or faith-based organisations, having particular regard to the availability of publicly funded health services, equality considerations...”*. In this context, we looked at the influence of religious ethos on the delivery of services. We discussed this issue in meetings with service providers, regulators and advocacy groups, and we asked questions on this point in our public consultation. We were informed that all publicly funded providers provide their services to persons of all faiths and none, and we did not see any evidence to the contrary. The question therefore seems to us not to be an issue of equality in terms of access to services but rather of what services these organisations are willing to provide in light of their ethos and values and how the State should react to their decisions.

The issue of what services are to be provided and funded by the State has come under the spotlight in the aftermath of the referendum to repeal the Eighth Amendment to the Constitution. It is hypothetically possible, for example, that a Catholic hospital may refuse to provide certain services. This debate raises legal questions as well as questions relating to the provision of state funding to hospitals that refuse to provide the full range of lawful services by reference to their religious ethos.

The full extent of the constitutional right of independently owned faith-based organisations to manage their own affairs has not yet been determined in the healthcare context by the Supreme Court. However, the State has an obligation to organise its health and social care services to ensure access to lawful services by all its citizens. Furthermore, health and social care organisations are obliged to comply with Irish law irrespective of their religious affiliation. Therefore, the State is legally entitled to attach reasonable conditions to any funding it provides and is free not to provide funding to organisations that refuse to provide certain lawful services. Such a decision is essentially a political rather than a legal one due to the fact that, given the significant level of services provided by Catholic hospitals in Dublin, Cork and Limerick, a decision not to provide any state funding to such hospitals would entail serious and prolonged disruption to the health service with consequent detriment to service users and the public.

Although we agree on the State's right not to fund organisations that opt out of providing lawful services, we recommend avoiding the serious consequences that could ensue from such a decision. Therefore, we recommend that the State should establish a list of essential services to be provided on its behalf, and either commission these services from the voluntary or private sectors, or decide to provide them directly through the public healthcare system. Subject to the availability of the necessary facilities and skills to ensure safe delivery of these services, the State should also ensure that they are provided as close as possible to those who wish to avail of those services. We also make recommendations on ensuring timely access to relevant patient information and on what should happen in emergency situations to ensure that the needs of the patient are regarded as paramount.

More generally, we recommend that a new funding approach is adopted by the State for all health and social care services, which would involve a move away from the current focus on providers to an approach of commissioning a list of essential services based on the needs of the local, regional and

national populations. This would allow the State to decide whether to provide services directly through the statutory system or to purchase them from the voluntary or private sectors.

Our recommendation to adopt a list of essential services to be funded by the State at a nationally agreed price would support a move towards funding services based on the assessed needs of the individual. This list of essential services could form the basis for commissioning those services from non-State providers based on an assessment of their ability to provide services which meet national standards of safety and quality. This would of course not preclude any organisation, whether voluntary, public or private, from providing additional services but these would not automatically be funded by the State.

During the process of this review we became conscious of a strained relationship between the voluntary sector and the State, represented by the HSE as the funding agency. There seems to us to be a breakdown in mutual trust and respect which must be restored in order to maintain this essential relationship in a healthier way for the benefit of all our citizens. We therefore recommend developing a new relationship between the State and the voluntary sector based on trust, partnership and on mutual recognition of need. To underpin a transparent and collaborative relationship, we recommend public recognition of the separate legal status and of the important role of the voluntary sector through a Charter based on principles such as putting the patient/service user at the centre of the system, shared purpose, active involvement, dialogue and joined up government. The Charter should be developed and its principles put into practice through a Forum, which should be established to facilitate regular dialogue between the relevant State representatives and the voluntary sector.

We heard a great deal from voluntary organisations in relation to repetitive requests for information in a variety of formats and templates from different units and individuals within the HSE. This imposes a huge time and resource burden on smaller organisations, as well as placing an unnecessary difficulty on the HSE to request and process that information multiple times. We noted the plan by the HSE to establish Contract Management Support Units (CMSUs) in each of the Community Healthcare Organisations (CHOs), which should improve the reporting arrangements, in particular for those large Section 39 organisations which currently have Service Arrangements (SAs) with multiple CHOs.

Furthermore, many voluntary organisations are also registered charities and/or companies. Therefore, in addition to reporting to the HSE, they are required to report the same or very similar information to the Charities Regulator and the Companies Office in respect of common issues such as governance and finance. We therefore propose that State bodies agree a Memorandum of Understanding to re-use data provided to them, and which is publicly available, instead of asking voluntary organisations to provide data that has already been supplied elsewhere. Furthermore, they should agree not to repeat verification and control work already done by another State body.

We make recommendations to re-balance the burden of current contractual relations between the voluntary sector and the HSE from a heavily bureaucratic emphasis on control of spending towards a greater focus on the quality of services delivered and outcomes. The heavy onus of compliance on some organisations and the amount of time and resources required of the HSE to ensure compliance seems to us in many cases to be disproportionate to the funding received. We therefore make recommendations in relation to simplifying the process of financial reporting in such cases.

We recommend a move to multi-annual budgets, initially for a 3-year period, to enable voluntary organisations to plan better and to factor innovative reform ideas and capital investment into the services

they provide. This will also provide greater certainty to the State, which relies on these organisations to provide essential services.

We recommend that the Department of Health play a stronger role in future in terms of policy involvement and as the parent department of the HSE. The HSE is an agency of the State but the content and direction of policy must be set by the Department under Ministerial guidance to ensure that the HSE delivers in line with Government policy.

Finally, we have developed our recommendations taking into account the changing policy framework in health and social care, notably Sláintecare, and we consider potential future developments in the health system and how they may relate to voluntary organisations.

The following table shows how our report responds to the detailed points of our mandate.

Terms of Reference	Response
Examine and inquire into the role played by voluntary organisations.	See Chapter 3 – History and context of voluntary organisations in health and social care services in Ireland up to the present day , Chapter 4 – The situation in other countries , and Chapter 5 – The added value of voluntary organisations
Seek views and consult with service providers, service users, the public, funders, regulators, and other interested parties.	Meetings held with key stakeholders – see Appendix 1 Public consultation held between 26/03/18 and 11/5/18 – see Department of Health website for the report on the public consultation.
Provide a factual report with an overview of the different types of legal status and governance structures of health and personal social service providers.	See Chapter 6 – Ownership, control and governance of voluntary organisations .
Outline any particular issues arising in connection with providing services through religious or faith-based organisations.	See Chapter 7 – Ethos
Make recommendations to the Minister for Health on the principles which should inform the future relationship between the State and voluntary service providers.	See Chapter 8 – Relationship between voluntary organisations and the State . See Recommendations: 6.4, 7.2, 8.1, 8.3-8.7, 8.11-8.12, 9.1-9.2, 9.4
Suggest options to the Minister for actions that would enhance the delivery of services and safeguard public investment, particularly where large capital investments are required or where withdrawal of services is being considered.	See Recommendations: 6.1-6.3, 7.1, 7.3-7.4, 8.2, 8.8-8.10, 9.3

2.2 List of recommendations

Chapter 6: Ownership, control and governance of voluntary organisations

<p>Recommendation 6.1</p>	<p>Assets to be re-invested in charitable bodies in Ireland</p> <p>Voluntary organisations should indicate publicly that, in the event of winding-up of the organisation, the proceeds of any asset sales would be re-invested in a charitable body with similar objectives in Ireland.</p>
<p>Recommendation 6.2</p>	<p>Database of charges on state-funded capital assets owned by voluntary organisations</p> <p>To protect the State's investment, the HSE should compile a database of all charges on capital assets owned by voluntary organisations and funded by the State. This should be updated and published at regular intervals. The HSE should also systematically verify whether there are any other charges on the same assets before granting funding.</p>
<p>Recommendation 6.3</p>	<p>Protection of future State investment in capital assets</p> <ul style="list-style-type: none"> i) Where the State decides to build any new hospital or facility, it should endeavour to ensure that it owns the land on which the hospital or facility is built. ii) Where the State is unable to secure the purchase of land on which it intends to develop a new facility, any capital investment by the State should only be provided subject to prior agreement on the services that will be delivered in this new facility and the governance arrangements that will apply.

Recommendation 6.4	<p>Review of governance arrangements</p> <ul style="list-style-type: none"> i) Boards of voluntary organisations should be required to demonstrate compliance and alignment with modern corporate governance standards specifically in relation to issues such as the appointment of Board members, Board size, competencies required, tenure and conflict of interest declarations. ii) Board members of voluntary organisations in receipt of state funding should undergo training in good corporate governance to enable them to undertake their responsibilities effectively. The State should co-fund such training for smaller organisations. iii) In the case of voluntary organisations receiving over 50% of their funding from the State and where this exceeds €20 million annually, ways should be found to strengthen State representation at Board level, for example through the appointment of Ministerial nominees or Public Interest Directors.
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Chapter 7: Ethos

Recommendation 7.1	<p>Inclusive mission statements</p> <p>All faith-based state-funded voluntary organisations should state clearly in their mission statements that their services are available to those of all faiths and none.</p>
Recommendation 7.2	<p>Religious décor</p> <p>Voluntary organisations in receipt of state funding should be cognisant of the impact of décor on patients/service users and strive to ensure that their personal preferences in this regard are met to the greatest extent possible.</p>
Recommendation 7.3	<p>Access to information and services</p> <ul style="list-style-type: none"> i) The State should provide full information about the availability of, and timely access to, all lawful services as close as possible to the location of the service user. ii) All organisations, including any that decide not to provide certain lawful services on grounds of ethos, should ensure that they provide service users with adequate information on the full range of services available in the State and how and where to access such services. iii) All organisations should make available all relevant patient records to ensure the safe and timely transfer of care.

Recommendation 7.4	<p>Emergency situations</p> <p>In emergency situations, the life and well-being of patients must always take precedence over the ethos of the organisation and therefore organisations must ensure that all legally permitted treatment is made available safely to the greatest extent possible within the capabilities available to the organisation.</p>
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Chapter 8: Relationship between voluntary organisations and the State

Recommendation 8.1	<p>List of essential services</p> <ul style="list-style-type: none"> i) A list of essential services to be funded by the State should be agreed in consultation with the voluntary sector. ii) Full cost prices for delivery of these services should be agreed centrally. iii) The list should be updated regularly, with provision for adjustment to meet local circumstances. iv) Appropriate national standards should be developed for services in the list of essential services, where these do not already exist. Organisations that provide these services should be robustly monitored by the appropriate agency to ensure their compliance.
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Recommendation 8.2	<p>Mapping of service provision by voluntary organisations</p> <p>The Department of Health and the HSE should undertake a full mapping of all voluntary organisations providing personal social care services receiving public funding, and of their capacity to provide a range of essential services in the coming years. The results of this mapping should be updated and published at regular intervals.</p>
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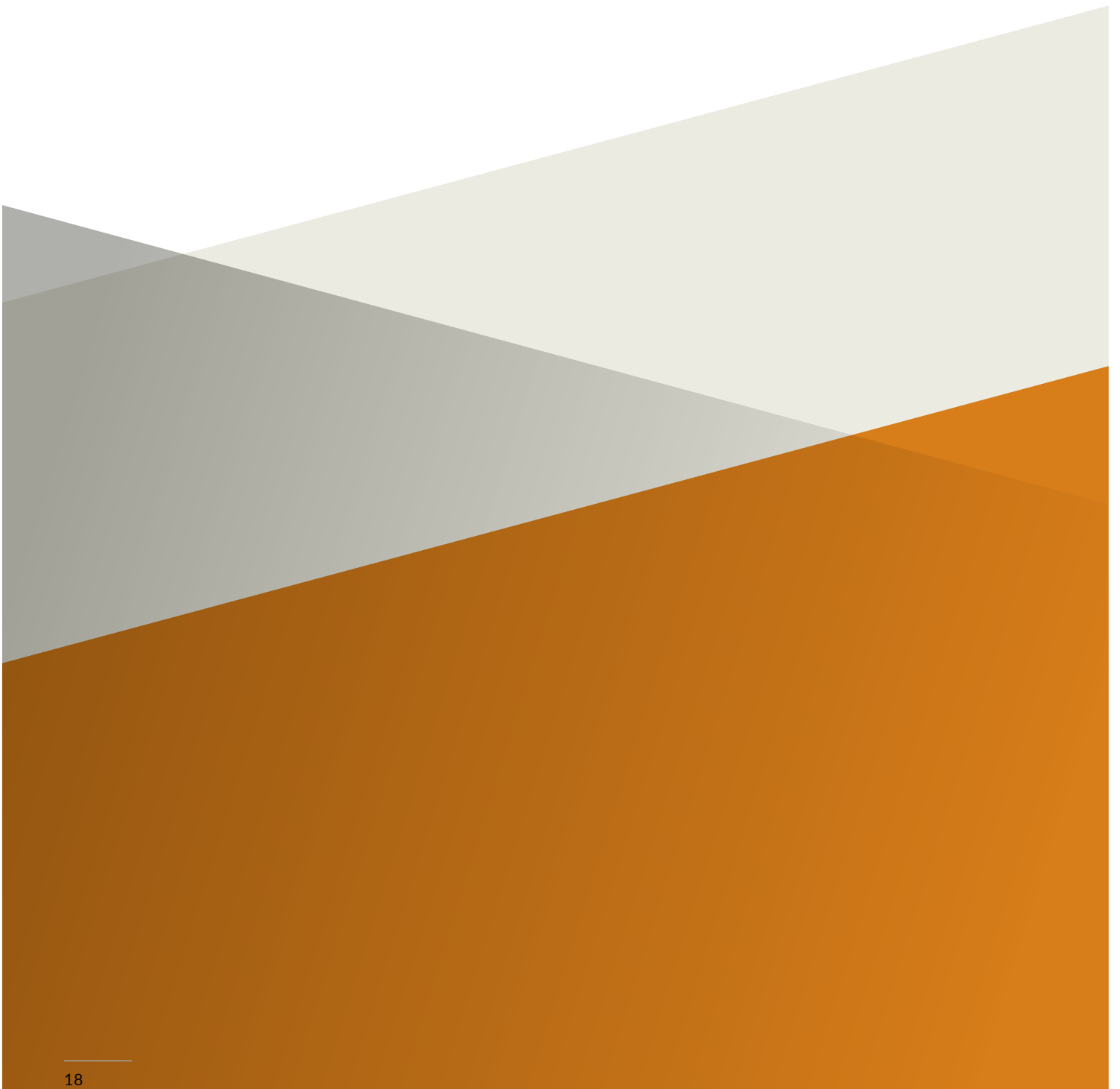
Recommendation 8.3	<p>Official recognition through a Charter</p> <p>A Charter should be drawn up to give official recognition to the legally separate status of the voluntary sector and to reflect its public service role in the provision of health and social care services. The Charter should be developed and agreed with the voluntary sector and adopted within a twelve-month period.</p>
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Recommendation 8.4	<p>A new Forum</p> <p>A Forum should be established to facilitate regular dialogue between the relevant State representatives and the voluntary sector to ensure their full involvement in future policy and strategic developments.</p>
Recommendation 8.5	<p>Revision of Service Arrangements and Grant Aid Agreements</p> <p>Working groups composed of representatives from the Department of Health, the HSE and voluntary organisations should be established, according to level of funding received, to review and simplify the Service Arrangements and Grant Aid Agreements with a view to introducing new arrangements by 2020. New arrangements should be applied on a trial basis and subject to an evaluation after the trial period.</p>
Recommendation 8.6	<p>Requests for information</p> <p>To ensure that information requests are necessary and proportionate, the HSE should develop a set of principles and processes governing information requests to organisations, which adhere to data protection principles and the best standards of information governance.</p>
Recommendation 8.7	<p>Avoiding duplication of requests for information</p> <ul style="list-style-type: none"> i) Requests for information that has already been provided to another arm of the State should be avoided. ii) A Memorandum of Understanding (MoU) should be agreed between the main relevant bodies which would commit them to re-using data already provided to other State bodies.
Recommendation 8.8	<p>Managing deficits</p> <p>The Departments of Health and Public Expenditure and Reform should undertake a review of the financial position of voluntary organisations that would include an analysis of surpluses/deficits over the last five years and the main drivers and put forward proposals for resolving any deficits identified.</p>
Recommendation 8.9	<p>Multi-annual budgets</p> <p>There should be a move to multi-annual budgets for 3-5 years in duration to facilitate strategic service planning and reform of services.</p>

Recommendation 8.10	<p>Integration of fundraising plans</p> <p>There should be open and transparent discussion on the financial capacity and fundraising plans of the voluntary sector as part of the Service Arrangement process.</p>
Recommendation 8.11	<p>Mechanism for resolving disputes</p> <p>An independent process should be put in place to resolve disputes (excluding the negotiation of budget allocations) between the HSE and voluntary organisations.</p>
Recommendation 8.12	<p>Role of the Department of Health</p> <p>The Department of Health should play a stronger role as the parent department of the HSE and in the interface between the HSE and the voluntary sector.</p>

Chapter 9: Future opportunities

Recommendation 9.1	<p>Future structures</p> <p>Voluntary organisations should be consulted fully regarding any future health structures so that a solution is agreed to enable them to retain their separate legal identity and autonomy, while ensuring that the services they contract to provide are part of an integrated concept for the whole region.</p>
Recommendation 9.2	<p>Dual role of commissioner/provider</p> <p>The roles of commissioner and provider of services should be separated.</p>
Recommendation 9.3	<p>Innovation fund</p> <p>An Innovation Fund should be created which would award grants (initially €20 million) on a competitive basis to innovative projects to be carried out in the voluntary and public sectors.</p>
Recommendation 9.4	<p>Support function</p> <p>A publicly funded support function should be established to help smaller voluntary organisations. This could provide access to training (for staff and Boards) and shared legal, accounting and other services.</p>



3. History and context of voluntary organisations in health and social care services in Ireland up to the present day

3.1 A brief history

The history of healthcare provision in Ireland in the early 18th century shows that the sick and poor were treated in infirmaries and by dispensary services funded by philanthropists, doctors and religious orders. *“Government in these islands had not yet accepted a general responsibility for the health of the population, nor a duty to make medical facilities available to all at little or no cost to the patient...Only the medical care of the very poor and the control of infections associated with poverty were considered to warrant public intervention”*¹¹. The role of the State in relation to free health provision in Ireland can be traced back to the Poor Relief (Ireland) Act 1851 as a result of which the Poor Law bodies took over these dispensaries and provided free services for those who were unable to pay for them¹².

The charitable and religious organisations which provided medical care to the sick and poor in their communities over time became known as voluntary organisations (i.e. supported by voluntary contributions). Jervis Street hospital (the Charitable Infirmary), founded in 1718, was the first voluntary hospital in Ireland¹³.

A number of voluntary organisations were established by benefactors. For example, in 1745 Bartholomew Mosse founded the Dublin Lying-In Hospital (now known as the Rotunda Hospital)¹⁴ and in 1826 Mrs. Margaret Boyle founded the Coombe Lying-In Hospital¹⁵.

During the 19th century, following Catholic emancipation, a number of Catholic religious orders founded large healthcare organisations, mainly in Dublin and Cork. For example, the Sisters of Charity founded St. Vincent’s Hospital in 1834¹⁶ and the Sisters of Mercy founded the Mercy Hospital in Cork in 1857¹⁷ and opened the Mater Misericordiae in Dublin in 1861¹⁸. Religious orders such as the Daughters of Charity¹⁹ and the Brothers of Charity²⁰ also began to provide services to people with intellectual disabilities and mental health needs during the 19th century.

During the 20th century, religious orders continued to be involved in the provision of health and social care. Voluntary organisations were also founded to meet local community needs, including for example disability services. Furthermore, groups of parents and friends began to establish voluntary organisations to support the needs of friends and family. For example, KARE was founded in 1967 by parents and friends of children with an intellectual disability²¹.

11 Barrington R., *Health, Medicine & Politics in Ireland 1900-1970*, (Institute of Public Administration 1987) p.4

12 Report of the Expert Panel on Medical Need for Medical Card Eligibility (Sept. 2014) p.11, available at <https://www.hse.ie/eng/services/publications/corporate/expertpanelmedicalneed.pdf>, accessed 12 June 2018.

13 Donnelly, B., *The historical development of Irish Hospitals and the importance of their records*, available at <http://historyofmedicineinireland.blogspot.com/2015/03/the-historical-development-of-irish.html>, accessed 2 August 2018.

14 <https://rotunda.ie/history-of-rotunda-hospital/>, accessed 4 September 2018.

15 <http://www.coombe.ie/index.php?nodeld=14>, accessed 4 September 2018.

16 <https://religioussistersofcharity.ie/what-we-do/>, accessed 2 August 2018.

17 <http://www.muh.ie/index.php/about-us>, accessed 2 August 2018.

18 <https://www.materprivate.ie/about/our-history/>, accessed 2 August 2018.

19 <http://www.docservice.ie/about-us-history.aspx>, accessed 26 September 2018.

20 <http://www.brothersofcharity.ie/history.php>, accessed 26 September 2018.

21 <http://www.cope-foundation.ie/About-Us/Our-History>, accessed 4 September 2018.

While voluntary organisations provided care at a time when the State did not, in the 20th century the scale of State provision and funding of health and social care expanded considerably and the voluntary and State systems began to work more closely together. The State also established new structures with specific responsibility for the planning and delivery of public health and social care services. Under the 1970 Health Act, eight regional Health Boards were established and further structural and organisational changes were made in the 1990s before the Health Service Executive (HSE) was established in 2005.

Today's mix of public, voluntary and private healthcare has evolved over many years, often in an ad hoc way rather than as a result of deliberate policy. More recently, there have been several efforts to overhaul and reform the health and social care system in response to increasing costs, technological advances in medicine and social care, and changing public attitudes and expectations.

3.2 The situation today

As a result of its history, today Ireland has a three-strand health and social care system with voluntary (independently owned and governed, not-for-profit)²², public (fully state-owned and governed, not-for-profit), and private (for-profit) hospitals and other organisations catering for the needs of the population. In line with our mandate, in this report we concentrate on the voluntary sector and its interaction with the State.

The 2004 Health Act sets out the legal framework for public funding of health and personal social care in Ireland²³. It states that the HSE shall manage and deliver, or arrange to be delivered on its behalf, health and personal social services²⁴. The HSE funds public hospitals and certain social care services directly under its authority, and is also the channel for state funding to voluntary organisations and other organisations that provide health and personal social care services. These are defined under Sections 38 and 39 of the Act:

Section 38 allows the HSE to “enter...into an arrangement with a person for the provision of health or personal social services by that person **on behalf of the Executive**”.

Section 39 makes similar provision for the HSE to “give assistance to any person or body that provides or proposes to provide **a service similar or ancillary** to a service that the Executive may provide”.

In 2017, 39 organisations received funding under Section 38 and over 2,000 organisations received funding under Section 39²⁵. The vast majority of these organisations are voluntary organisations²⁶.

22 We use the terms ‘voluntary organisations’ and ‘voluntary sector’ throughout this report when referring to independently owned and governed, not-for-profit organisations.

23 Health Act 2004, available at <http://www.irishstatutebook.ie/eli/2004/act/42/enacted/en/print>, accessed 13 August 2018.

24 We use the term ‘health and social care’ throughout this report when referring to health and personal social services.

25 HSE Annual Report and Financial Statements 2017.

26 Four organisations funded under Section 38 are not voluntary organisations. These four organisations – St. James’s Hospital, Beaumont Hospital, Dublin Dental Hospital, and Leopardstown Park Hospital – are known as Joint Board hospitals. They are state-owned, audited directly by the Comptroller and Auditor General, and their Board members are appointed by the Minister for Health, thus distinguishing them from voluntary organisations, which retain partial or full autonomy in the appointment of Board members. There are a number of private service providers funded under Section 39.

Diversity of voluntary organisations

Voluntary organisations providing health and social care services vary significantly in terms of size, geographical coverage and the range of services provided. They include:

- Large, acute teaching hospitals such as St. Vincent's University Hospital, Mater Misericordiae University Hospital, Tallaght University Hospital, and Mercy University Hospital;
- Specialist hospitals such as the Royal Victoria Eye and Ear Hospital, Cappagh National Orthopaedic Hospital, and maternity hospitals in Dublin – the Rotunda, Coombe Women and Infants University Hospital, National Maternity Hospital;
- National level disability providers such as Rehab Group, Irish Wheelchair Association, Brothers of Charity Services, Saint John of God;
- Hospices such as Our Lady's Hospice and Care Services, St. Francis Hospice, Galway Hospice Association;
- Regional non-acute care services in areas such as mental health and rehabilitation such as Clonmany Mental Health Foundation, and Local and Regional Drug and Alcohol Task Forces;
- Small community-based support groups and social care services such as Meals on Wheels and social clubs;
- Advocacy and representative groups, such as the Disability Federation of Ireland, Inclusion Ireland.

3.3 The scale of the voluntary sector

We examined the scale of the voluntary sector through a number of lenses. We looked at levels of funding, capacity and activity. Given our specific mandate to consider issues in relation to organisations that are religious or faith-based, we also considered the scale of this subset of voluntary organisations.

In 2017, €14.2 billion in revenue funding was allocated by the State to the HSE for health and social care²⁷. As set out in Table 1, a significant portion of this was subsequently allocated to voluntary organisations – totalling approximately 23% of overall funding²⁸.

Category (No. of voluntary organisations)	2017 (€m)	2016 (€m)	2015 (€m)
Section 38 (35)	2,366.1	2,250.2	2148.6
Section 39 (>2,000)	949.7	874.4	839.2
Total	3,315.7	3,124.6	2,987.8

Table 1 - Total revenue funding to Section 38 and Section 39 organisations²⁹

27 HSE Annual Report and Financial Statements 2017.

28 Derived from HSE National Finance Division figures and HSE Annual Report and Financial Statements 2017.

29 Derived from HSE National Finance Division figures and HSE Annual Report and Financial Statements 2017. The figures for Section 38 organisations do not include St. James's Hospital, Beaumont Hospital, Dublin Dental Hospital, and Leopardstown Park Hospital. The figures for Section 39 organisations primarily cover funding to voluntary organisations, and this accounts for the vast majority of funding, however a small amount of this funding covers, for example, National Lottery Grants, Home Care Packages and Personal Assistance Services and others.

There are 14 voluntary acute hospitals, which received €1.43 billion of the revenue funding allocated under Section 38 in 2017³⁰. Voluntary hospitals account for 28% of in-patient beds in publicly funded acute hospital care³¹. According to Hospital In-Patient Enquiry (HIPE³²) data, in 2017 voluntary hospitals accounted for 26% of in-patient discharges from publicly funded acute hospitals.

There are different ways of counting the number of voluntary acute hospitals which are faith-based due to the variety of ownership and governance arrangements in place (see Chapter 6 for further details). We therefore considered both of these aspects.

With regard to ownership, we consider that there are seven voluntary acute hospitals with ownership structures in which faith-based organisations currently play a role³³, as shown in Table 2.

Mater Misericordiae University Hospital
St. Vincent's University Hospital
Temple Street Children's University Hospital
Mercy University Hospital, Cork
Cappagh National Orthopaedic Hospital
St. Michael's Hospital, Dun Laoghaire
St. John's Hospital, Limerick

Table 2 - Voluntary acute hospitals with ownership structures in which faith-based organisations currently play a role³⁴

These seven hospitals received a total of €786 million in revenue funding through the HSE in 2017³⁵.

In relation to governance, in some voluntary acute hospitals religious orders retain the power to nominate or approve Board members while in others, members of religious orders sit on the Boards solely on an ex-officio basis. This means that, in total, 12 out of the 14 voluntary acute hospitals have some degree of faith-based involvement in their governance arrangements, as shown in Table 3.

Mater Misericordiae University Hospital (MMUH)
St. Vincent's University Hospital
Tallaght University Hospital
Our Lady's Children's Hospital, Crumlin
Temple Street Children's University Hospital
Mercy University Hospital, Cork
National Maternity Hospital
Rotunda Hospital
Cappagh National Orthopaedic Hospital
St. Michael's Hospital, Dun Laoghaire
St. John's Hospital, Limerick

Table 3 - Voluntary acute hospitals with any degree of religious involvement in governance arrangements³⁶

30 Derived from HSE Annual Report and Financial Statements 2017.

31 Derived from HSE Business Intelligence Unit data.

32 HIPE is a health information system designed to collect demographic, clinical and administrative information on discharges and deaths from acute hospitals nationally. HIPE information is available at <http://www.hpo.ie/>

33 Throughout the report we have used terms such as 'owned by faith-based organisations' or 'owned by religious orders' when referring to organisations with ownership structures in which faith-based organisations currently play a role.

34 Ordered by size of 2017 HSE funding allocation. See Appendix 2 for further detail.

35 Derived from HSE Annual Report and Financial Statements 2017.

36 Ordered by size of HSE funding allocation. See Appendix 3 for further details.

Furthermore, some voluntary organisations are currently in a state of transition related to wider health system developments. For example, the Sisters of Charity have announced their intention to end their involvement in St. Vincent's University Hospital and St. Michael's Hospital, and the new National Children's Hospital will consolidate the paediatric services currently provided by Our Lady's Children's Hospital Crumlin, Temple Street Children's University Hospital and the paediatric services provided at Tallaght University Hospital. We understand from our meetings with stakeholders that a number of other voluntary organisations are currently in the process of secularising their governance arrangements.

In the coming years, therefore, it is likely that the number of voluntary acute hospitals owned by religious orders will be reduced to four – the Cappagh National Orthopaedic Hospital and Mater Misericordiae University Hospital in Dublin, Mercy University Hospital in Cork, and St. John's Hospital in Limerick. These four hospitals received €404.5 million revenue funding in 2017³⁷.

The majority of disability services are provided by voluntary organisations. 80% of residential places for people with disabilities are provided by voluntary organisations³⁸ and the National Disability Authority estimates that one third of all disability services are provided directly by the HSE while two thirds are provided by voluntary organisations³⁹.

A number of large disability service providers funded under Section 38 are faith-based: Brothers of Charity Services Ireland, Carriglea Cairde Services, Daughters of Charity Disability Support Services, Saint John of God Community Services. These organisations account for approximately 58% of the funding allocated to disability service providers under Section 38⁴⁰.

Three of the top thirty funded organisations under Section 39 are faith-based organisations: Marymount Hospice, St. Francis Hospice, Milford Care Centre, all providing palliative and hospice care. These organisations account for approximately 7% of the funding allocated to the top thirty funded organisations under Section 39⁴¹.

It is important to mention that voluntary organisations also play a role in relation to, among others, mental health services, services for older people, advocacy and community support. We have not examined the scale of voluntary service provision in each of these areas in detail. However, we met with a broad range of stakeholders spanning the variety of type and size of voluntary organisation and identified many common issues across the sector.

3.4 Differences between Section 38 and Section 39 voluntary organisations

Table 1 shows that there are differences of scale between the relatively small number of voluntary organisations (35) receiving state funding under Section 38 and the very large number of voluntary organisations (over 2,000) funded under Section 39.

However, at an individual organisation level, the distinction between Section 38 and 39 organisations is not meaningful in terms of either the type of service provider, the services provided, or the level of funding received. By way of illustration, acute hospitals are only funded under Section 38 but there are

37 Derived from HSE Annual Report and Financial Statements 2017.

38 Sourced from HSE.

39 National Disability Authority submission to the Independent Review Group.

40 Derived from HSE Annual Report and Financial Statements 2017.

41 Derived from HSE Annual Report and Financial Statements 2017.

some disability service providers and hospices funded under Section 38 and others funded under Section 39.

Section 38 contains a number of large scale organisations which receive hundreds of millions in funding each year. This includes voluntary acute hospitals and national level disability service providers. However, Section 38 also includes some small hospices and residential services receiving less than €20 million in funding.

There are no acute hospitals funded under Section 39. The majority provide disability services. A small number of national level service providers receive significant levels of funding (in excess of €30 million), but the vast majority receive much smaller amounts. In 2017, the top 30 funded organisations accounted for 53% of the almost €1 billion funded under Section 39⁴². 1,687 grants of under €100,000 were allocated by the HSE in 2017, totalling €30.5 million or approximately 3% of the total Section 39 funding⁴³.

Table 4 shows the number of Section 38 and Section 39 organisations receiving different levels of funding.

Funding level	Number of Section 38 voluntary organisations	Number of Section 39 organisations
Over €250 million	2	0
Between €100 million - €250 million	6	0
Between €50 million - €100 million	8	1
Between €40 million - €50 million	1	1
Between €20 million - €40 million	9	7
Between €5 million - €20 million	7	29
Between €1 million - €5 million	2	113
Between €250,000 - €1 million	0	156
Between €100,000 - €250,000	0	194
Less than €100,000	0	1,687
Total	35	2,188

Table 4 - Number of Section 38 (voluntary only) and Section 39 organisations in each funding tranche, 2017⁴⁴

However, the distinction between Section 38 and Section 39 organisations is very important when it comes to the terms and conditions of staff. Staff in organisations funded under Section 38 of the 2004 Health Act are public servants with the same terms and conditions as those who work in HSE services. Staff in organisations funded under Section 39 of the 2004 Health Act are not public servants and these

42 Derived from HSE National Finance Division figures and HSE Annual Report and Financial Statements 2017.

43 Derived from HSE National Finance Division figures and HSE Annual Report and Financial Statements 2017.

44 Derived from HSE Annual Report and Financial Statements 2017. The majority of organisations funded under Section 39 are voluntary organisations, though not all. For the 1,687 grants of less than €100,000, the number of organisations in question may be slightly lower e.g. due to an organisation receiving separate grants from different HSE sections/locations/areas etc.

organisations are not bound by public sector terms and conditions of employment. The issue of pay restoration for workers in Section 39 organisations who had their salaries cut during the financial crisis has been the subject of discussions with the State. We have not examined this issue as it does not fall within our mandate. However, it was raised in a number of our meetings with stakeholders and it is clear that it has placed a strain on the relationship between voluntary organisations and the State.

3.5 Reliance on public funding

Voluntary organisations providing health and social care services often generate their own funding, for example through donations, bequests and fundraising, as well as from statutorily imposed patient charges and private health insurance payments. However, public funding represents a significant portion of many voluntary organisations' income.

The Benefacts report 'Non-profit Sector Analysis 2018, Understanding Ireland's third sector'⁴⁵ found that for the not-for-profit sector as a whole, "*giving by Irish and international philanthropic institutions to Irish Nonprofits represents a tiny fraction of the sector's €12.1bn turnover*".

The 'Registered Irish Charities Social and Economic Impact Report 2018'⁴⁶ report commissioned by the Charities Regulator and conducted by Indecon found that charities in Ireland receive a significant proportion of their income from the State and that large charities in particular have a significant dependency on public funding. The report found that public funding accounted for 65.4% of the total income of 'Hospitals and Other Health Organisations', and 94.5% of the total income of 'Disability and Other Charities Primarily Funded by HSE or Other Government Funding'⁴⁷.

While the level of public funding received by voluntary organisations providing health and social care varies greatly, we have found that, in most cases, it represents the majority of income for those organisations.

3.6 The case of faith-based voluntary organisations

Our mandate asked us to look specifically at "*the changing patterns of religious affiliation in the population, changes in the organisations providing such services (including declining vocations to religious life)*" as part of our overall review of the role played by voluntary organisations in the provision of health and social care services in Ireland.

As outlined above, there is a subset of voluntary organisations that are faith-based and many of these have been involved in service provision for many years.

In recent years, Irish society has become more pluralistic, and multi-cultural and the numbers of those who declare a religious affiliation have been declining. According to census data from the Central Statistics Office (CSO)⁴⁸, the proportion of the population identifying as Roman Catholic has fallen from 91.6% of the population in 1991 to 78.3% in 2016. The percentage of people indicating 'No Religion' has increased from 1.9% in 1991 to 9.8% in 2016, making it the second largest group. This is shown in Table 5.

45 Non-profit Sector Analysis 2018, Understanding Ireland's third sector, Benefacts, April 2018.

46 Registered Irish Charities Social and Economic Impact Report 2018, Indecon, July 2018, available at <https://www.charitiesregulator.ie/media/1489/social-and-economic-impact-report-2018.pdf>, accessed 6 September 2018.

47 Idem., p.12.

48 Central Statistics Office, available at <https://www.cso.ie/en/releasesandpublications/ep/p-cp8iter/p8iter/p8rrc/>, accessed 13 July 2018.

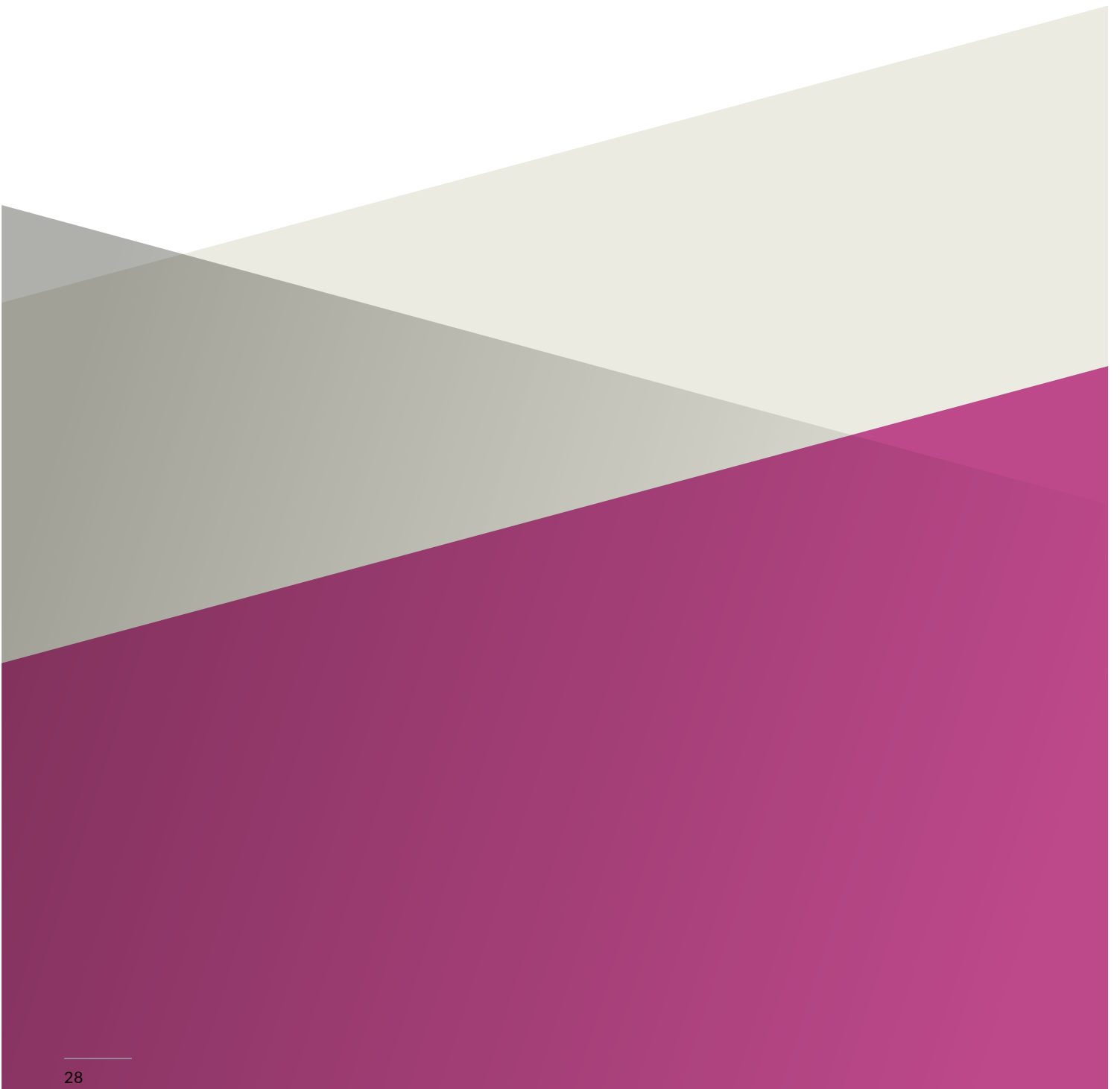
Religion	1991	2002	2006	2011	2016
Roman Catholic	91.6	88.4	86.8	84.2	78.3
No religion	1.9	3.5	4.4	5.9	9.8
Church of Ireland	2.5	3.0	3.0	2.9	2.8
Muslim (Islamic)	0.1	0.5	0.8	1.1	1.3
Presbyterian	0.4	0.5	0.6	0.5	0.5

Table 5 – Religious affiliation of the population (as a percentage of total population)⁴⁹

Unless the situation changes in the future, the small number of new entrants and the age profile of members of Catholic religious orders inevitably mean that the direct involvement of religious orders in a number of voluntary organisations will come to an end. This has already led these faith-based organisations to examine their structures. Many have moved or are moving to transfer their activities to companies supervised by Boards with a majority of lay members.

Some members of religious orders have withdrawn completely from sitting on the Boards of organisations owned by their orders. In some cases, the power of religious orders to nominate Board members has been relinquished while in others the religious orders have retained the right to appoint lay members to the Boards to preserve the values and mission of the organisations into the future. This raises important questions about the influence of religion on the delivery of publicly funded health and social care which are considered in Chapter 7.

⁴⁹ Ibid.



4 The situation in other countries

The development of the voluntary sector in Ireland has followed a path similar to many other countries which have long traditions of health and social care provided by religious and philanthropic organisations. We therefore examined the role of this sector in the delivery of health and social care services in a selection of other potentially comparable countries. While we did not undertake a comprehensive review, we commissioned research from the Health Research Board (HRB) and participated in a dialogue event with experts from Portugal, France, Germany and Belgium facilitated by the European Observatory on Health Systems and Policies⁵⁰. We also sought information through Irish Embassies in a number of EU countries. This allowed us to identify a number of common characteristics, particularly among a group of EU countries, which show that trends in Ireland are similar to elsewhere in the EU and can serve as models from which we can learn.

4.1 Role and scale of the voluntary sector in other countries

A recent analysis of Comparative Healthcare Systems⁵¹ concludes that there is little direct relation between the size of the welfare State and that of the not-for-profit sector. It identifies two factors which shape the development of the welfare sector, namely the balance of social forces (religion, class conflicts, women's movements and the capacity and development of the State) and the timing and sequencing of the struggles and institutionalisation of these forces. Since the mix and evolution was different in each country there is no overall 'model'.

The size and role of the voluntary sector varies from country to country. Thus, for example, in Ontario, Canada, not-for-profit hospitals are the main providers of acute care (making up 149 out of 155 hospitals)⁵². By contrast, in England they do not appear to play a role in acute care but are very involved in the provision of health and social care in the community⁵³.

A common characteristic of EU countries such as France, Germany, Belgium and Portugal, is that the voluntary sector is an important provider of health and social care services⁵⁴, as shown in Table 6.

Country	Publicly owned	Not-for-profit (voluntary)	For-profit privately owned
France	1389	691	1009
Germany	806	979	1323
Ireland	34	14	22
Portugal	114	54	57

Table 6 - Number of publicly owned, not-for-profit (voluntary), private for-profit hospitals in selected countries, 2015⁵⁵

50 <http://www.euro.who.int/en/about-us/partners/observatory>. Accessed 01 October 2018.

51 Prof. Seán O'Riain, Comparative Healthcare Systems, April 2018. Part of the submission to IRG by Mater Misericordiae and the Children's Hospital Company.

52 J. Quigley and J. Long, *Governance of voluntary health and social care providers* – England and Canada, Health Research Board, 2018.

53 Ibid.

54 European Observatory on Health Systems and Policies, evidence briefing event held in Dublin, 18 June 2018.

55 OECD Health Statistics 2017.

The public service role of voluntary organisations in all the countries we considered is an integral part of the overall delivery of services. The contribution of the voluntary sector in those countries is valued for its capacity to innovate, to react quickly and to be more flexible than the public sector, as well as for its ability to advocate for patients' and service users' interests. In several countries, the voluntary sector is viewed as sharing the values of public service and is often seen as effectively being part of the public sector without being integrated into it. A French law dating from 1970⁵⁶ on public hospital services, which is updated regularly, provides a set of principles to be followed by both the voluntary and public sector and these still apply today⁵⁷. These principles include requirements for continuity of service, equal access, universality and neutrality.

The issue of religious ethos (see Chapter 7) is dealt with differently in the countries we examined. In Ontario, Canada, it is possible for organisations to take an institutional position. Operational or policy directives issued from the Minister to the Board of a hospital *“shall not unjustifiably as determined under Section 1 of the Canadian Charter of Rights and Freedoms require the board of a hospital that is associated with a religious organization to provide a service that is contrary to the religion related to the organization”*⁵⁸. In France, organisations authorised to provide public hospital services may only refuse to provide services if other institutions are able to respond to local needs⁵⁹.

By contrast, in other countries we looked at, such as England, it is individuals rather than institutions who may conscientiously object to providing these services⁶⁰. In Belgium, the debate is still continuing as to whether such services should be made available in all institutions⁶¹.

4.2 Funding frameworks in other countries

One of the notable features of the countries we considered is the operation of structured processes for funding and/or commissioning services. While these differ from country to country and can be influenced by the nature of the funding system for health (e.g. social insurance systems etc.) and the extent to which the roles of purchaser and provider have been separated, the presence of more formal commissioning arrangements would appear to provide for a more effective relationship between the state and voluntary organisations.

In many countries, the state fixes the range of services to be provided and service providers are involved in different ways in deciding on the list of services. The public authorities fix the prices to be paid for these services, which can include provision for capital and operating costs. In federal countries such as Germany and Belgium, where there is strong subsidiarity, prices may be fixed at regional level. In most cases, funding is multi-annual. Services are then contracted on the basis of the agreed price list.

The fact that prices are determined centrally (and usually independently), separately from the service delivery contract negotiation process, allows the commissioning service and the regional/local providers

56 Loi n°70-1318 du 31 décembre 1970 portant réforme hospitalière.

57 Art. L. 6112-1, LOI n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé.

58 J. Quigley and J. Long, *Governance of voluntary health and social care providers – England and Canada*, Health Research Board, 2018.

59 For example, see Article L2212-8 of the Code de la santé publique relating to abortion (available at https://www.legifrance.gouv.fr/affichCodeArticle.do;jsessionid=2547E79615907ED36B5805711705BC31.tplgfr28s_1?idArticle=LEGIARTI000033865551&cidTexte=LEGITEXT000006072665&dateTexte=20180924&categorieLien=id&oldAction=&nb Result Rech=).

60 J. Quigley and J. Long, *Governance of voluntary health and social care providers – England and Canada*, Health Research Board, 2018.

61 European Observatory on Health Systems and Policies, evidence briefing event held in Dublin, 18 June 2018.

to focus their discussions on the best mix of services to be delivered taking local circumstances into account. To varying degrees, there is considerable autonomy for the service provider to decide how best to deliver the agreed services, provided they meet national standards of quality and safety. These features seem to lead to a more service user driven outcome that focuses on their needs rather than on the status of the provider. Some of these countries are working towards more integrated, person-centred approaches. For example, Flanders, Belgium is currently running a pilot scheme to test personal assistance budgets managed directly by adults with physical disabilities⁶².

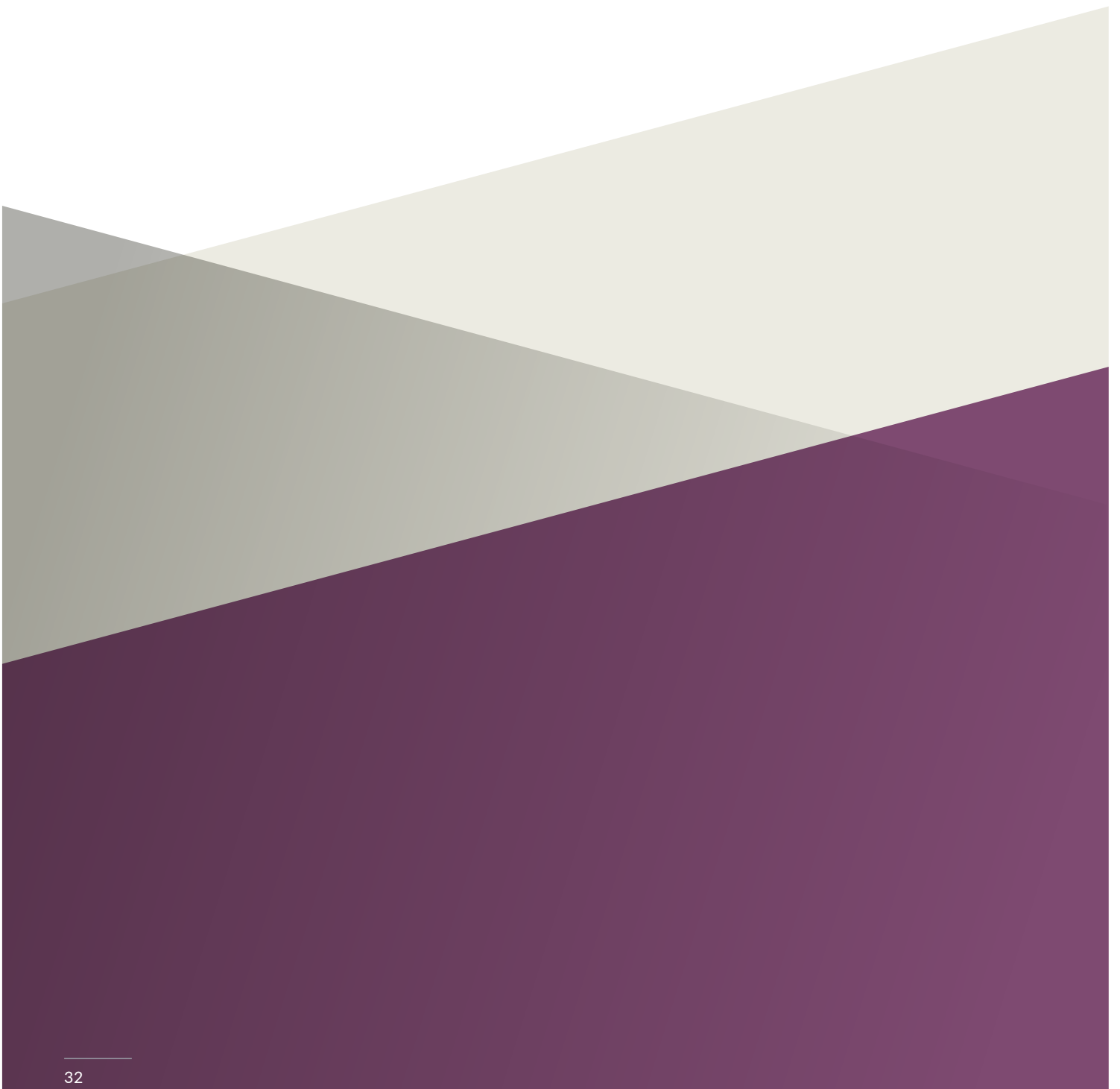
4.3 Conclusions

All of the countries mentioned above are facing significant challenges in healthcare delivery, including adjusting to changing demographics, increasing demand and costs, the challenge of immigration, rising public expectations, finding the right balance between centralisation and local autonomy, and dealing with data collection and sharing issues. All countries also struggle to find the best way to include the patient/service user voice in consultation on policy and on delivery of services.

Despite differences between the voluntary and public or private providers, the regulatory framework governing patient safety and quality assurance requires common standards of all providers as well as equal access, non-discrimination and neutrality at the point of delivery. This framework helps to ensure that the impact of the ownership of voluntary organisations is neutral from the point of view of delivery of service and that the voluntary sector is seen broadly as a welcome and trusted partner with a long-term place in the provision of health and social care.

In many of the countries we considered, the voluntary sector provides the 'glue' between the public sector, the private sector and family/community. However, the delineation between the voluntary sector and the public sector is becoming increasingly blurred, mainly as a result of the very high levels of public funding the voluntary sector receives. The degree of choice available to each user of the health system varies from country to country but all are wrestling with the problem of offering choice while containing costs. As a result, there is an ongoing process of consolidation among service providers as part of cost containment and providers are increasingly collaborating to deliver better outcomes.

⁶² We note that the Task Force on Personalised Budgets published a report on the issue in Ireland - Towards Personalised Budgets for People with a Disability in Ireland, Report of the Task Force on Personalised Budgets, Department of Health, June 2018.



5 The added value of voluntary organisations

In many ways, public and voluntary organisations providing health and social care services are similar as both operate as not-for-profit organisations. They share common values of delivering the highest standard of care to all who need it and of treating service users with compassion and dignity. Their staff can be said to have a public service commitment. Statutory and voluntary organisations are, in effect, different and legally distinct components of the same overarching public system. They are both part of Hospital Group and Community Healthcare Organisation structures and they are subject to the same regulation and standards where these exist.

However, there are differences. Voluntary organisations have the ability to raise their own funds by fundraising and from donations and legacies, though as has been shown in Chapter 3, for most this represents a small proportion of their total income. Public and the bigger voluntary organisations receive the large majority of their funding from the State (the other main sources of income are statutorily imposed patient charges and private health insurance income). Voluntary organisations differentiate themselves in the level of goodwill they garner and in their greater ability to leverage community support in the form of volunteers. This represents a valuable resource and provides community benefit as volunteers give their time and expertise freely for the well-being of their fellow citizens. That said, their public counterparts also benefit from this support, though perhaps to a lesser extent.

Another important difference is that, in general, voluntary organisations have Boards, which is only the case for a small number of state-owned hospitals such as Beaumont and St. James's. Boards are designed to provide a direct level of corporate governance through accountability of management to the Board, and to bring a level of governance oversight to the operation of organisations. Board members give their services voluntarily (i.e. without payment) and usually bring a local and community dimension as well as their own personal and professional expertise to bear on the work of the organisations they govern. This is viewed as a tremendous asset by the organisations themselves and it is an important public service on the part of those who volunteer to give their time and expertise freely to support a wide variety of organisations.

Local managers in voluntary organisations appear to retain more autonomy and decision-making powers than their peers in the public sector. There is a widespread view that accountability and decision-making have become too concentrated at the top of the HSE. This can impede empowered decision-making and responsiveness at a local level in HSE hospitals and other services. There is often a very long span of governance and management control within certain HSE services. As a consequence, individuals in managerial roles have accountability without necessarily having the authority to make decisions. By comparison, one of the positive features of voluntary organisations is that there is more autonomy and authority at local management level which encourages a more prompt, flexible and responsive approach to problem-solving and supports the piloting of quality improvement initiatives.

In meetings with representatives of the health and social care sectors (see Appendix 1) and through a public consultation⁶³ we invited people to set out what they perceived as the strengths and weaknesses of the voluntary sector.

⁶³ The sample size of the consultation was relatively small. See report in 2018 Consultations, www.health.gov.ie/consultations.

There was widespread agreement that the voluntary sector brings innovation, flexibility, independence and strong commitment to delivery of health and social care. This is consistent with findings in other countries⁶⁴. By being rooted in their communities voluntary organisations are responsive to local needs and can advocate on behalf of the best interests of service users. Voluntary organisations can also challenge public policy and public sector organisations, and lobby for change in ways that the public sector cannot. This may sometimes be uncomfortable for those in authority but it is a necessary part of a vibrant and progressive democracy. The local identity of many voluntary organisations allows for citizen involvement and helps to build an inclusive democracy. The capacity of some voluntary organisations to raise funds was also seen as a positive feature.

In the public consultation, replies identified and ranked the strengths of the sector, as shown in Table 7.

Ranking	Strength
1	Links to community and advocacy role
2	Flexibility
3	Independence and autonomy
4	Quality of staff and volunteers
5	Ability to fundraise
6	Capacity for innovation

Table 7 - Strengths of voluntary organisations

Respondents were asked how the strengths they had identified could be supported and preserved into the future. The replies included calls for governance measures allowing an appropriate level of autonomy, multi-annual and full cost funding, personalised budgets for individuals, reduced micromanagement and empowerment of Boards of voluntary organisations to exercise leadership. There were also calls for better relations with the HSE, based on trust and partnership, reduction in administrative burden, and greater involvement of the voluntary sector in the formulation of policy and in preparing for the introduction of new policy and administrative changes.

We have also had the opportunity to consider the weaknesses in the current system – both in terms of effectively managing a health system where a significant proportion of services are delivered by non-state organisations, and within voluntary organisations themselves.

There will be a constant tension between the effective delivery of services at a system level on the one hand and respecting institutional autonomy on the other. The State must be able to determine system-wide policies, frameworks and standards for health and social care delivery and to make decisions on the provision and continuity of health and social care services. Some may argue that this would be much simpler if the State owned and controlled all the health and social care organisations which it funds. However, this would result in the loss of the very real value which the voluntary sector brings today.

With regard to the weaknesses of voluntary organisations, some of the stakeholders we met expressed frustration that some organisations may enter into financial commitments without regard to budgetary

⁶⁴ European Observatory on Health Systems and Policies, evidence briefing event held in Dublin, 18 June 2018.

constraints. Others criticised some voluntary organisations as being too selective in the clients they will accept.

Respondents to the public consultation identified and ranked the weaknesses of voluntary organisations, as shown in Table 8.

Ranking	Weakness
1	Lack of resources
2	Weak governance
3	Difficulties in recruitment and retention
4	Lack of partnership and strategic approach
5	Duplication
6	Subject to high burden of reporting

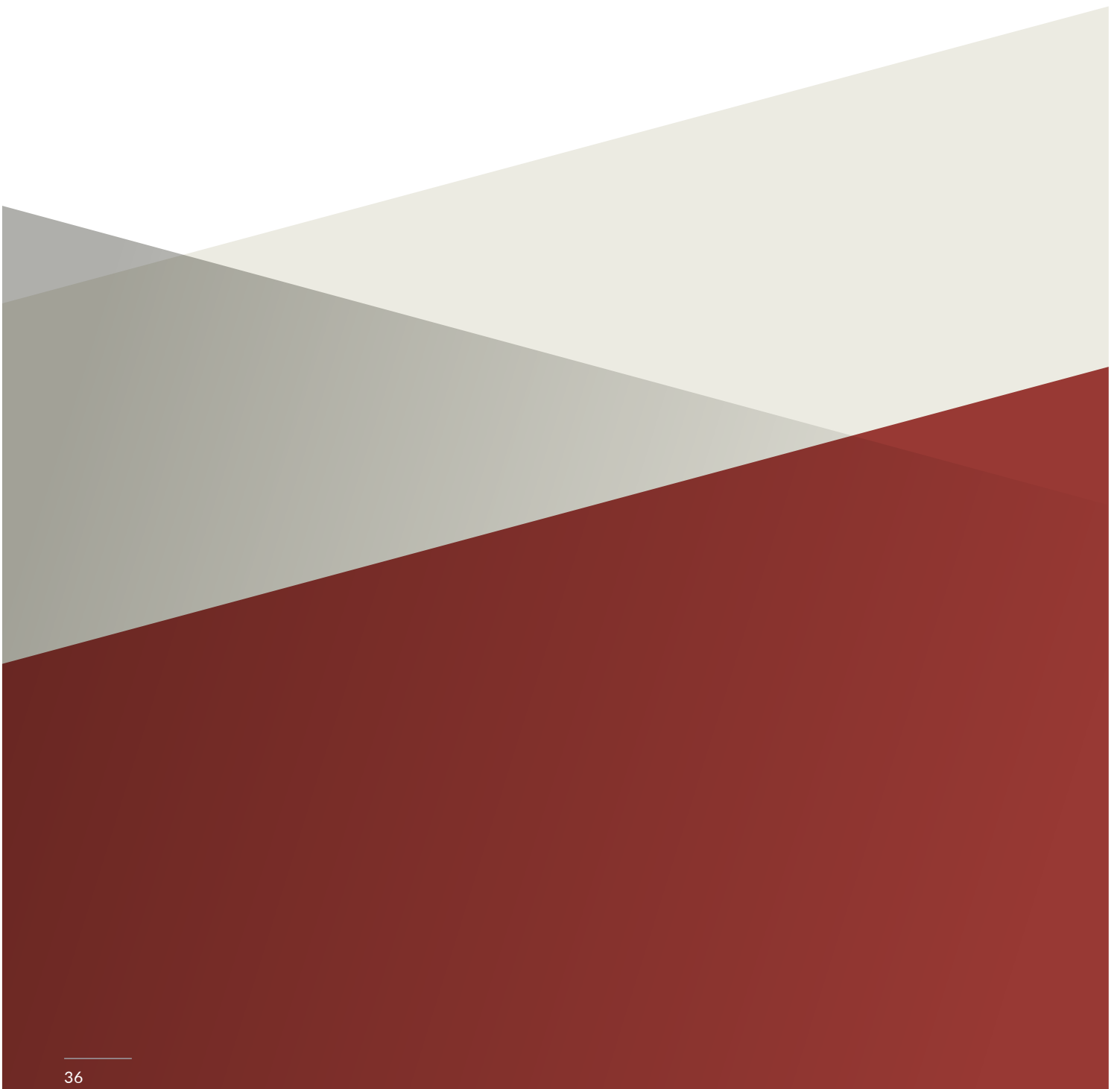
Table 8 - Weaknesses of voluntary organisations

With regard to weaknesses in governance, issues raised included a lack of necessary expertise among the Boards of organisations, poor financial governance, poor succession planning, and the high pay levels of senior managers. Respondents also felt that it is difficult for voluntary organisations to meet the numerous reporting and compliance obligations, and that there may be too many voluntary organisations operating in the same area and providing the same or very similar services.

Some of the issues identified as weaknesses stem directly from the financial constraints of the crisis years but others highlight ongoing issues on which we make recommendations later in this report.

In our view, voluntary organisations bring added value to Irish health and social care. The challenge in today's context is to find ways of preserving this capacity into the future, sharing learning and proposals for reform between the voluntary and public sectors, and developing an effective and appropriate relationship between the State and the voluntary sector.

Given the diversity of voluntary organisations in terms of size, structure, ethos, and type of services provided, it follows that the issues arising for these organisations will vary. It is also true that there will be no "one size fits all" model for the State in defining its relationship with voluntary organisations; this will depend on factors including the scale of the organisation. We address these issues in the following chapters.



6 Ownership, control and governance of voluntary organisations

Our Terms of Reference required us to provide a factual report with an overview of the different types of legal status and governance structures of voluntary organisations providing health and social care services. Since the majority of state funding to the voluntary sector goes to organisations funded under Section 38, we focused in particular on Section 38 organisations receiving over €20 million in funding in 2017⁶⁵. This is in line with the requirement in our Terms of Reference to provide “*more detailed factual information on the major acute hospitals and such other major providers as the Review Group may deem appropriate*”.

We looked at regulatory arrangements, ownership of assets, governance structures and related issues – including for the subset of voluntary organisations that are faith-based. This chapter sets out our findings, with further detail available in Appendix 2 on the ownership of assets, with particular regard to disposal of assets in the event of a winding-up, and Appendix 3 on governance structures, with particular regard to Board composition and appointment processes.

6.1 The legal structure of voluntary organisations

There are a number of different legal structures that may be used by health and social care voluntary organisations wishing to pursue a common objective, including registered companies, partnerships, unincorporated associations, charities, charter companies, trusts and so on. Each structure has different characteristics, benefits, and regulations attached to it.

Voluntary organisations that choose to incorporate and become a registered company most often decide to become a Company Limited by Guarantee (CLG), with other common company types chosen including a Private Company Limited by Shares (LTD) or a Designated Activity Company (DAC)⁶⁶. A registered company is a separate legal entity, distinct from those who run it. It owns its own assets and can sue, and be sued, in its own name. The principal advantage of incorporation for the shareholders is that if a limited liability company incurs debts that remain unpaid, it is the company and not the individual shareholders who may be sued in relation to those debts.

Companies are subject to strict regulation and must comply with the Companies Acts in relation to important matters such as making annual financial returns, complying with detailed rules on corporate governance, declarations of solvency, duties of directors and other officers, and the protection of creditors.

65 With the exception of Our Lady’s Children’s Hospital, Crumlin and Temple Street Children’s University Hospital as a single statutory entity will take over the services currently provided by Our Lady’s Children’s Hospital Crumlin, Temple Street Children’s University Hospital and the paediatric services provided at Tallaght University Hospital.

66 Prior to the Companies Act 2014, the structures and terminology used in company law were somewhat different but the principles of incorporation, registration with or without limited liability, and regulation by the Companies Registration Office (CRO) were broadly similar. The website of the CRO (<https://www.cro.ie/Registration/Company>) explains: *The shares in a company are owned by its shareholders. If the company is a limited liability company, the shareholders’ liability, should the company fail, is limited to the amount, if any, remaining unpaid on the shares held by them. A company is a separate legal entity and, therefore, is separate and distinct from those who run it. Only the company can be sued for its obligations and can sue to enforce its rights. There are several types of limited company: Private Company Limited by Shares (LTD company); Designated Activity Company (DAC); Designated Activity Company Limited by Guarantee (DAC) – (limited by guarantee); Company Limited by Guarantee (CLG) (limited by guarantee not having a share capital); Public Limited Company (PLC).*

The Companies Registration Office (CRO) and the Office of the Director of Corporate Enforcement (ODCE) both play a role in this regard.

Organisations that have a charitable purpose only and provide public benefit may register as a charity. Charitable purposes include the prevention or relief of poverty, the advancement of education, the advancement of religion, or any other purpose that is of benefit to the community⁶⁷ such as the promotion of health and voluntary work. Registered charities are subject to the rules of the Charities Act 2009 and are regulated by the Charities Regulator to ensure that the charity carries out its charitable purposes for the public benefit, keeps proper books of account, and provides annual reports and accounts to the Regulator. Charities may be able to avail of special tax treatment but they do not have any exemptions from other legislation.

An organisation can be both a registered charity and a company, for example a 'Company Limited by Guarantee' or 'Designated Activity Company'. The majority of voluntary organisations we looked at were a mix of these types (see Appendix 3). A small number of organisations were established by Royal Charter, Statutory Instrument, Scheme of Management or were unincorporated associations.

Voluntary organisations which originated in a religious order may also be Public Juridic Persons (PJP)⁶⁸. This means that they may consider themselves to be subject in some respects to canon law, which is a set of internal rules set down by Catholic Church leadership for the governance of its members. Board members of such organisations may be bound by the terms of their appointment to uphold the values and mission of the religious order. A number of issues arise in this context in relation both to the ownership of assets and the services provided by the organisation. The latter issue is dealt with in Chapter 7.

6.2 Regulation of voluntary organisations

In addition to regulation by the CRO, the ODCE and the Charities Regulator in terms of financial accounting and good governance, service providers in the area of health and social care are subject to regulation by sector-specific regulators. Where regulation for the health and social care sector is in place, it applies equally to the public and voluntary sectors.

By way of illustration, the Health Information and Quality Authority (HIQA) has differing powers in the social care sector and in the acute healthcare sector but in both instances both public and voluntary organisations fall under its remit. In addition, national standards published by HIQA apply to both the public and voluntary sectors⁶⁹.

It is worth noting that HIQA is not required to take the financial capacity of inspected organisations into account in making its recommendations and has no power to provide funding to implement its recommendations. It is also important to note that, unlike in social care residential centres, HIQA has no statutory enforcement powers in the healthcare area; it can only monitor and report. It is expected that this will change when a licensing system is introduced⁷⁰.

67 Charities Act 2009, section 3.

68 Can. 116 §1. "Public juridic persons are aggregates of persons (*universitates personarum*) or of things (*universitates rerum*) which are constituted by competent ecclesiastical authority so that, within the purposes set out for them, they fulfil in the name of the Church, according to the norm of the prescripts of the law, the proper function entrusted to them in view of the public good". Code of Canon Law http://www.vatican.va/archive/ENG1104/_PD.HTM, accessed 25 September 2018.

69 For example, National Standards for Safer, Better Healthcare, June 2012, available from <https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare>, accessed 19 August 2018. National Standards for Prevention and Control of Healthcare Associated Infections, May 2009, available from <https://www.hiqa.ie/reports-and-publications/standard/2009-national-standards-prevention-and-control-healthcare> accessed 19 August 2018.

70 General Scheme of the Patient Safety (Licensing) Bill, available at <https://health.gov.ie/wp-content/uploads/2017/12/12-Dec-General-Scheme-Patient-Safety-Licensing-Bill.pdf> accessed 18 September 2018.

There are also several other regulatory bodies that interact in different ways with voluntary organisations involved in the provision of health and social care services. This includes the Health and Safety Authority, the Health Products Regulatory Authority, the Food Safety Authority of Ireland, the Mental Health Commission, and professional regulatory bodies such as the Medical Council, the Nursing and Midwifery Board of Ireland, the Dental Council, and the Health and Social Care Professionals Council.

While this can place an administrative burden on voluntary organisations, public organisations are subject to the same level of regulation. Voluntary organisations, like every other form of organisation in the State, are also obliged to be aware of, and compliant with, Irish law.

6.3 Ownership of assets

Over the years, both the State and voluntary organisations have invested in the development, upkeep and refurbishment of healthcare facilities in the ownership of voluntary organisations across the country.

In many cases the State, through the HSE, funds capital assets such as the purchase of houses for residential care or the construction of new buildings in hospital facilities owned by a voluntary organisation. These assets are then used by the voluntary organisation to provide services. In other cases, the voluntary sector makes its own assets available and the State pays it to run services using those assets.

Voluntary organisations have contributed large sums of money over the years to the building of new facilities, purchase of new equipment, and the provision of financial support for staff training and research activities. This may be made possible by fundraising activities, donations, legacies and so on. It is also important to note that over many years religious orders made their land and buildings available without charge to the State and their members worked without salary or pension rights to deliver health and social care services.

Thus, there has been an element of cross subsidisation between the voluntary and the public sector over many years. However, with the increase in state-funded healthcare in the twentieth century, most voluntary organisations became contractors to the state, receiving regular payment for delivering a wide variety of care services. Today, the recent financial crisis, the limited scope for philanthropic giving in modern Ireland, and the decline in religious vocations have seriously reduced, if not exhausted, the possibility of future cross subsidisation.

6.3.1 Disposal of assets

Although a detailed examination of the ownership of each voluntary organisation's assets was not possible in the timeframe available to us, we tried to achieve greater clarity on this issue (see Appendix 2). Since the majority of state funding to the voluntary sector goes to organisations funded under Section 38, we wrote to Section 38 organisations receiving over €20 million in revenue funding in 2017⁷¹ (i.e. a total of twenty-four voluntary organisations), including those owned by religious orders. We asked them a series of questions designed to ascertain, for example, whether the assets were owned by a Public Juridic Person, a company or other legal structure, and to whom the assets would be transferred in the

71 With the exception of Our Lady's Children's Hospital, Crumlin and Temple Street Children's University Hospital as a single statutory entity will take over the services currently provided by Our Lady's Children's Hospital Crumlin, Temple Street Children's University Hospital and the paediatric services provided at Tallaght University Hospital.

event of a winding-up of the organisation, since the right to winding up an organisation is the ultimate expression of ownership⁷².

Where a voluntary organisation is a registered company, the assets are owned by the company as a separate legal entity. Where the company is a subsidiary of a holding company or one of a number of companies in a group, the question of ownership can become more complex and it can be difficult to ascertain exactly where ownership and control actually lies. Where the assets are held by a religious order, there may also be a Public Juridic Person (PJP)⁷³ in existence. This is an organisation, comprised of both lay people and members of religious orders, created under canon law that is able to act in the name of the Church and has the right to acquire, retain, administer, and alienate ecclesiastical goods⁷⁴. In such cases, the members of the PJP act as trustees on behalf of the entity.

As outlined previously, the vast majority of voluntary organisations are registered as charities. This includes almost all Section 38 voluntary organisations that are owned by religious orders. Section 92 of the Charities Act 2009 sets out that “*Where a charitable organisation is dissolved, the property, or proceeds of the sale of the property, of the charitable organisation shall not be paid to any of the members of the charitable organisation without the consent of the Authority, notwithstanding any provision to the contrary contained in the constitution of the charitable organisation*”⁷⁵. Moreover, guidance from the Charities Regulator for organisations wishing to register as a charity includes standard clauses relating to winding-up. These set out that if, upon the winding-up of an organisation, there remains any funds or property, these must be transferred to some charitable body having similar main objects, or failing that, to some other charitable object with the agreement of the Charities Regulator⁷⁶. This means that the assets of many voluntary organisations must be used for similar charitable purposes in the event of a winding-up. However, legally the decision on future use of assets rests with the organisation in question in the first instance and not with the State.

With regard to the twenty-four voluntary organisations we examined in detail, half have a standard clause in their constitution or memorandum of association on the disposal of assets in the event of winding up. Under this clause any property remaining would be transferred to a charitable institution or institutions having main objects similar to the main objects of the company, and the distribution of income and property among members is prohibited. In these instances, members of the company select the institution, or, if that is not possible, it is left to the Charities Regulatory Authority to make that decision. These provisions are in line with the requirements of the Charities Act. In other cases, voluntary organisations have already specified the institution(s) to which assets would be transferred. We did not find examples of provisions to transfer the proceeds of asset sales outside of the State but this does not appear to be precluded. In view of the fact that many of these assets have been funded by the State and by the general public (through fundraising etc.) over many years, we recommend that the relevant organisations indicate publicly that the proceeds of any asset sales would be re-invested in a charitable body with similar objectives in Ireland.

72 Further detail can be found at Appendix 2.

73 See footnote 68.

74 “A juridic person... is an artificial person, distinct from all natural persons or material goods, constituted by competent ecclesiastical authority for an apostolic purpose, with a capacity for continuous existence and with canonical rights and duties like those of a natural person... conferred upon it by law or by the authority which constitutes it and to which it is also accountable under canon law.” Robert T. Kennedy, “Juridic Persons” in *New Commentary on the Code of Canon Law*, ed. John P. Beal et al. (New York/Mahwah, NJ: Paulist Press, 2000) 155.

75 Charities Act 2009, section 92 on dissolution of charitable organisation.

76 Model Constitution – CLG, Model Constitution – Unincorporated Entities, available at <https://www.charitiesregulator.ie/en/information-for-charities/guidance-for-charities>, accessed 14 September 2018.

Some religious orders are internally bound by canon law in respect of property owned by the order. This might mean, for example, that sales or transfers of assets require authorisation from within the hierarchy of the Catholic Church or might be subject to decision of the hierarchy as to the use to which the proceeds of sale may be put. However, the ownership of property and assets by religious orders is subject to Irish civil law in the same way as ownership of assets by any other organisation.

Recommendation 6.1

Assets to be re-invested in charitable bodies in Ireland

Voluntary organisations should indicate publicly that, in the event of winding-up of the organisation, the proceeds of any asset sales would be re-invested in a charitable body with similar objectives in Ireland.

6.3.2 Protection of State investment

For many years, the cross subsidisation between the State and voluntary organisations was done on an ad hoc basis. In particular, the State invested significant monies in capital developments without any formal legal protections for this investment and legacy issues can arise as a result.

Since the creation of the HSE in 2005, it is a requirement that the State takes a charge on all capital investments it funds in voluntary organisations⁷⁷. Part 2 of the Service Arrangement with the HSE specifies *“Where capital assets are funded/part funded by the HSE, the State’s interest should be protected through entering into a grant agreement with the HSE and the asset should be used for the purpose as set out therein and will not be sold or used as security for any loan or mortgage without the prior agreement of the HSE”*⁷⁸. Voluntary organisations that return Annual Compliance Statements to the HSE (that is, all Section 38 organisations and Section 39 organisations receiving greater than €3 million in annual funding) are required to confirm that *“where a capital asset is funded / part-funded by the Executive, the State’s interest has been protected by the Provider through entering into a Grant Agreement prepared by the Executive which sets out the terms and conditions detailing the basis upon which the Executive has provided and the Grantee has accepted the Capital Grant including the security required by the Executive, to protect the State’s interest in the asset”*⁷⁹.

We understand that the HSE holds a charge (usually for 40 years) on all capital assets which it funds. In the event of a breach of the agreement with the HSE, the charge would allow the HSE to recover the entirety of the capital grant, if necessary through the forced sale of the property or equipment. The charge generally only covers capital investment that has taken place since the establishment of the HSE and does not cover capital provided by the State prior to that time.

As far as we can ascertain, the HSE does not appear to have a full list of all assets for which it holds charges and although its own guidance document⁸⁰ refers to the need to check whether there are other charges on the same assets as part of its decision-making on funding, it is not clear to us that this requirement is met in every case.

77 HSE National Financial Regulation 18 – Protecting the HSE’s Interest, available at <https://www.hse.ie/eng/staff/resources/financial%20regulations/nfr-18-protecting-the-hse’s-interest.pdf>, accessed 19 September 2018.

78 Service Arrangement documentation for Section 38 organisations is available at <https://www.hse.ie/eng/services/publications/non-statutory-sector/section-38-documentation.html>, and for Section 39 organisations at <https://www.hse.ie/eng/services/publications/non-statutory-sector/section-39-documentation.html>, accessed 13 August 2018.

79 2017 Annual Compliance Statement for Section 38 organisations is available at <https://www.hse.ie/eng/services/publications/non-statutory-sector/section-38-documentation.html>, and for Section 39 organisations at <https://www.hse.ie/eng/services/publications/non-statutory-sector/section-39-documentation.html>, accessed 15 August 2018.

80 Protecting the State’s Interest, HSE Guidance Document.

Recommendation 6.2**Database of charges on state-funded capital assets owned by voluntary organisations**

To protect the State's investment, the HSE should compile a database of all charges on capital assets owned by voluntary organisations and funded by the State. This should be updated and published at regular intervals. The HSE should also systematically verify whether there are any other charges on the same assets before granting funding.

6.3.3 Future State investment

The National Development Plan (NDP) provides for a considerable programme of investment in new capacity and new facilities in the health sector⁸¹. This includes the already approved developments of the new National Children's Hospital on the site of St. James's Hospital and the new National Maternity Hospital on the site of St. Vincent's Hospital. These projects have highlighted the complexity that can arise with the amalgamation and co-location of services.

In the case of the new Children's Hospital, it will be located on State land and will be fully owned by the State. The assets of Our Lady's Hospital, Crumlin will transfer to the new Children's Hospital, while the assets of Temple Street will remain in the ownership of the Mater Misericordiae and the Children's University Hospitals Company Limited by Guarantee (MMCUIH). While no decisions have been made on what will happen to either property once the services have transferred to the new hospital, we understand that they will continue to be used for charitable health purposes. Governance arrangements have been agreed between the Department and the three voluntary organisations and are set out in the draft legislation⁸².

The question of governance of the new National Maternity Hospital at Elm Park was the subject of extensive mediation between the National Maternity Hospital and the St. Vincent's Healthcare Group, which culminated in the Mulvey Agreement⁸³. In line with that agreement, a new company will be established to run the hospital – The National Maternity Hospital at Elm Park DAC (limited by shares) – which will be a 100% subsidiary of the St. Vincent's Healthcare Group. A legal framework to protect the State's considerable investment in the hospital is under development and this will be agreed with both hospitals. The proceeds of the sale of the Holles St. buildings will be invested in the new facility.

While each case of amalgamation or co-location of services is unique, we feel that some useful lessons could be drawn for the future from recent examples. For example, since the State is likely to be the main funder of both buildings and the services provided in any new case of amalgamation or co-location, we recommend that the State should always seek to own the land on which future hospitals or facilities will be built. The State can buy new greenfield sites or purchase sites from existing owners or receive land and buildings as donations. This would cost the Exchequer more than in the past but would leave the State free to determine the ethos, guiding principles and governance of any future organisation. Where the State is unable to secure the purchase of land on which it intends to develop a new facility, any capital investment by the State should only be provided subject to compliance with a prior agreement on the

⁸¹ National Development Plan 2018-2027.

⁸² Children's Health Bill, 2018.

⁸³ Kieran Mulvey, Report to the Minister for Health Simon Harris, T.D. on the Terms of Agreement between the National Maternity Hospital (Holles St.) and St. Vincent's Hospital Group regarding the Future Operation of the New Maternity Hospital – "The National Maternity Hospital at Elm Park DAC", November 2016.

services that will be delivered in the new facility and the governance arrangements that will apply. Such an agreement should be in place before the development goes ahead.

Recommendation 6.3	<p>Protection of future State investment in capital assets</p> <ul style="list-style-type: none"> i. Where the State decides to build any new hospital facility, it should endeavour to ensure that it owns the land on which the hospital or facility is built. ii. Where the State is unable to secure the purchase of land on which it intends to develop a new facility, any capital investment by the State should only be provided subject to prior agreement on the services that will be delivered in this new facility and the governance arrangements that will apply.
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6.4 Governance

There has been much discussion of the concept of corporate governance in Ireland in recent years. Corporate governance broadly speaking is the system by which organisations direct and control their functions in order to achieve organisational objectives, manage their business processes, meet required standards of accountability, integrity and propriety, and relate to their external stakeholders. International experience supports the concept that organisations need to have modern management capability with the required authority and accountability. This enables sound decision-making at senior management level, allows for delegated decision-making as close as possible to the level of care delivery and involves clinicians centrally in the process.

In the context of healthcare, the Commission on Patient Safety⁸⁴ recommended in 2007 that all healthcare organisations must have in place a governance framework which clearly describes responsibilities, delegated levels of authority, reporting relationships, and accountability within the organisation. The Commission was of the view that good governance was crucial in terms of issues such as advocating for positive attitudes and values about safety and quality in the organisation, performance management, managing risk, reporting adverse events, using data to improve clinical effectiveness and evidence-based practice, managing patient complaints effectively at a local level, and ensuring service user participation.

The Commission also recommended that a Board should be established close to the point of delivery of service and that it should regularly review the systems of governance within the organisation, including risk management and audit, relating to healthcare safety, quality and performance. Other important advantages of a Board are its local connectedness and visibility both within the organisation and the community it serves. This enables the Board to provide effective leadership which is widely recognised as being important in setting the direction of an organisation, developing its culture, ensuring delivery and maintaining effective governance. It also provides mechanisms of accountability and support for the Chief Executive/Manager of the organisation, with clear lines of communication, ease of access to speedy decision-making, responsiveness and mutual trust.

⁸⁴ Commission on Patient Safety and Quality Assurance, *Building a Culture of Patient Safety* (Department of Health 2007) https://health.gov.ie/wp-content/uploads/2014/03/en_patientsafety.pdf.

In general, voluntary organisations have Boards in place, and as discussed in Chapter 5, this is seen as one of their key strengths. Our analysis of governance structures as set out in Appendix 3 shows that Boards are in place in each of the twenty-four voluntary organisations we examined. Most of these Boards have an upper limit of 12-16 members – but this is much higher in some instances. Levels of representation on Boards for staff and ex-officio members also vary widely. For a number of organisations, information on governance arrangements is not readily available in a format which would be clearly understandable by patients or service users. We consider that in the interests of transparency, organisations which have not already done so should make information on their governance arrangements readily available and easily understood.

It is also worth noting that the mere existence of a Board is not enough in itself to guarantee good governance. Some Boards are established on the basis of historic charters etc. which have not been updated to reflect modern requirements and practice. This can lead to Boards that are very large and where membership is not necessarily competency-based. Such factors can make decision-making slow and complicated and can reduce capacity for reform and adaptation. It can also lead to risk in terms of patient safety, and a lack of openness and transparency. Situations can also arise where a circular process of nominations between Boards and nominating bodies takes place.

There have been some high-profile cases in the health and social care sector in recent years⁸⁵ where Boards have failed to play their role in holding the executive level to proper account. Fortunately, these are the exception, but they have spurred a drive to improve corporate governance and to professionalise Boards in the voluntary sector. However, these high-profile cases appear to have undermined public trust and had an impact on voluntary organisations' ability to fundraise. While it is not possible to link it to specific events, public opinion polling data does show that public trust in charities declined from 69% in April 2011 to 47% in April 2017⁸⁶.

Our analysis shows that many of the largest voluntary organisations have adapted their governance structures and processes. However, some have not and run the risk of diverging from current best practice in both the private and public sectors. The expertise of Board members is also an important factor in ensuring good corporate governance and they must be supported to fulfil their roles effectively.

We recommend that those voluntary organisations that have not yet done so modernise their governance arrangements to bring them into line with current best practice and ensure that individual Board members have the appropriate skill sets and commitment to fulfil their responsibilities and collectively have the breadth of knowledge and competencies to carry out the Board's duties. Guidance is available from the revised 'Code of Practice for the Governance of State Bodies', the Charities Regulator and the 'Code of Practice for Good Governance of Community, Voluntary and Charitable Organisations in Ireland'⁸⁷. Additionally, HIQA national standards already exist which provide guidance to health service providers to help establish effective leadership, governance and management⁸⁸. In some cases, organisations may

85 For example, see transcript of Public Accounts Committee, 15 July 2016 available at https://www.oireachtas.ie/en/debates/debate/committee_of_public_accounts/2016-07-15/2/ accessed 12 September 2018.

86 Irish Charity Engagement Monitor, November 2017, nfp Synergy Base 1,000 adults 16+, Ireland as reproduced on p.14 of the Report of the Consultative Panel on the Governance of Charitable Organisations, Charities Regulator, 5 April 2018 available at <http://www.charitiesregulator.ie/en/CRA/Report%20of%20the%20Consultative%20Panel%20on%20the%20Governance%20of%20Charitable%20Organisations%20May%202018.pdf/Files/Report%20of%20the%20Consultative%20Panel%20on%20the%20Governance%20of%20Charitable%20Organisations%20May%202018.pdf>

87 A Code of Practice for Good Governance of Community, Voluntary and Charitable Organisations in Ireland (<http://www.governancecode.ie/>), Report of the Consultative Panel on the Governance of Charitable Organisations, 5 April 2018 available at <https://www.charitiesregulator.ie/media/1389/report-of-the-consultative-panel-may-2018.pdf>, Code of Practice for the Governance of State Bodies, Department of Public Expenditure and Reform, August 2016.

88 For example, National Standards for Safer, Better Healthcare, June 2012, available from <https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare>, accessed 19 August 2018.

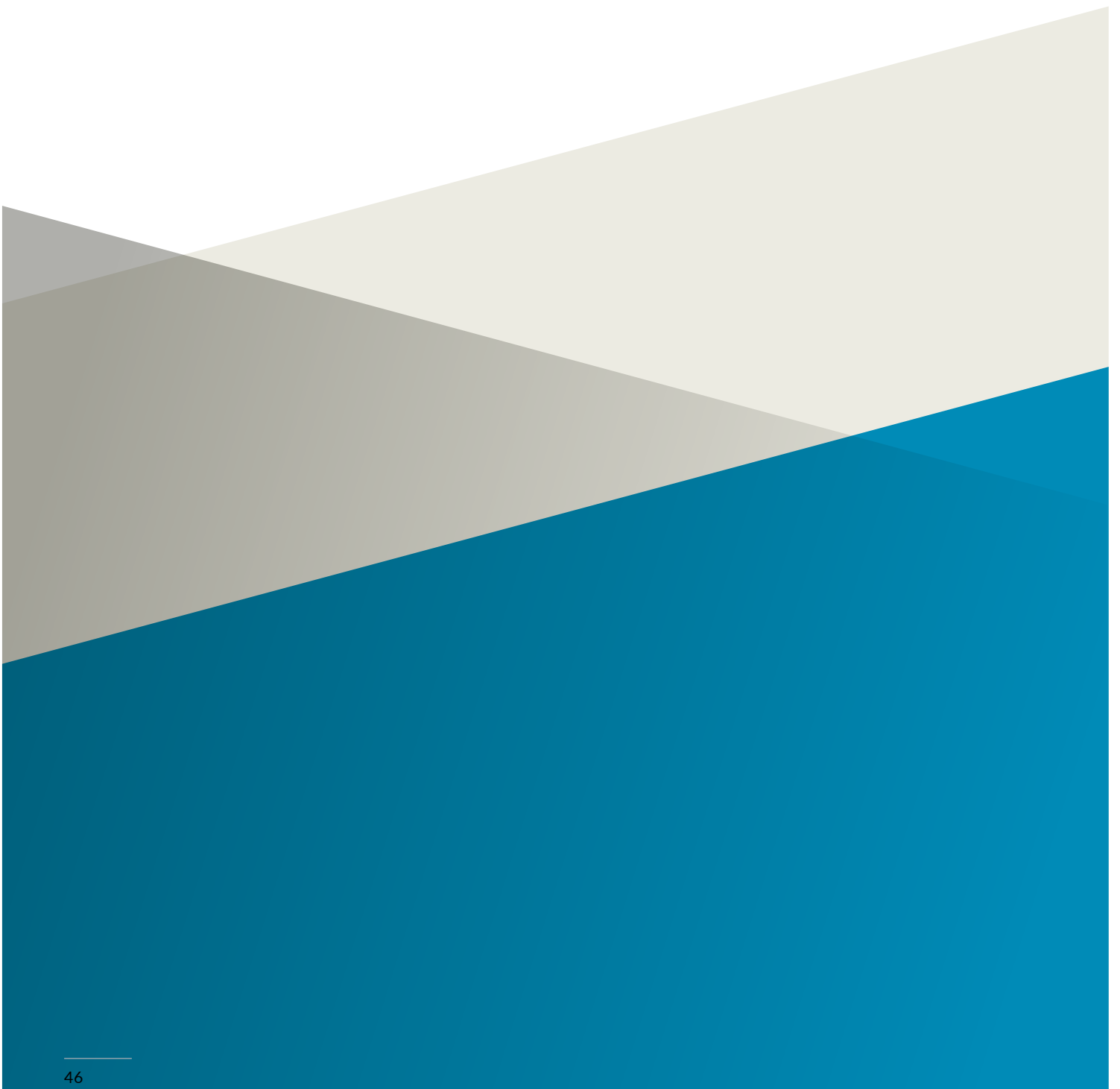
need to seek approval from the High Court or to request legislative change in order to change their basic charter or constitution.

Given the scale of state funding to many of these organisations, both in terms of operational and capital costs, we considered whether any changes were needed to ensure that the State's interest is taken into account in the work of these Boards. We see a difference in terms of the necessary balance between autonomy and control for organisations that receive most of their income from the State, on the one hand, and those that receive less than 50%, on the other. Therefore, for organisations receiving over 50% of their funding from the State and where that amount exceeds €20 million a year, we recommend finding ways of providing stronger State representation on the Boards of these organisations. For example, this could include the appointment of public interest directors or Ministerial appointments to the Boards. A number of approaches may be required given the differing legal structures of voluntary organisations.

Recommendation 6.4

Review of governance arrangements

- i. Boards of voluntary organisations should be required to demonstrate compliance and alignment with modern corporate governance standards specifically in relation to issues such as the appointment of Board members, Board size, competencies required, tenure and conflict of interest declarations.
- ii. Board members of voluntary organisations in receipt of state funding should undergo training in good corporate governance to enable them to undertake their responsibilities effectively. The State should co-fund such training for smaller organisations.
- iii. In the case of voluntary organisations receiving over 50% of their funding from the State and where this exceeds €20 million annually, ways should be found to strengthen State representation at Board level, for example through the appointment of Ministerial nominees or Public Interest Directors.



7 Ethos

Our Terms of Reference asked us to consider “any particular issues arising in connection with providing services through religious or faith-based organisations, having particular regard to the availability of publicly funded health services”.

In order to consider these issues, we began by examining the extent of the involvement of faith-based voluntary organisations in the provision of health and social care services today. We then considered the mission statements of a number of faith-based and secular organisations as these represent public expressions of their ethos, and we provide some examples in this Chapter. We then considered a number of issues which could arise in the context of faith-based voluntary organisations, including access to services and range of services provided. Given the historical dominance of the Catholic Church in the sector, we focused on Catholic hospitals. We examined the link between state funding and services, specifically in the context of the provision of reproductive health services and in emergency situations.

7.1 Faith-based voluntary organisations in receipt of state funding

Acute hospitals

At present there are 48 public and voluntary acute hospitals in the State⁸⁹. As explained in Chapter 3 we consider that currently seven of these are owned by faith-based organisations with a further five having some degree of faith-based involvement in their governance arrangements (see Appendices 2 and 3 for full details). This number is likely to decrease in the coming years as a result of ongoing amalgamations and recently announced ownership/governance decisions. All twelve of these acute voluntary hospitals (which have some degree of faith-based involvement in their ownership or governance) are located in Dublin, Cork and Limerick. They are of national and regional significance in terms of the scale of health care they provide and the state funding they receive. These twelve hospitals account for 26% of in-patient beds in publicly funded acute hospital care⁹⁰. They received €1.34 billion in revenue funding in 2017⁹¹.

Disability services

Ireland ratified the UN Convention on the Rights of Persons with Disabilities in 2018. The Convention states in Article 25 that parties to the Convention shall:

- a) *Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.*⁹²

There are a number of large state-funded voluntary organisations providing disability services which are faith-based or have faith-based organisations in their governance arrangements. This raises the question of the impact of ethos on the services they provide, for example with regard to the sexual and reproductive

89 <https://www.hse.ie/eng/services/list/3/acutehospitals/hospitals/hospitalist.html>, accessed 28 September 2018.

90 Derived from HSE Business Intelligence Unit data.

91 Derived from HSE Annual Report and Financial Statements 2017.

92 UN Convention on the Rights of Persons with Disabilities, available at <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html>, accessed 26 July 2018.

health and rights of those in residential care. These issues did not arise prominently in our meetings with stakeholders or in the public consultation. We therefore decided to focus primarily on acute hospital services in considering the question of ethos. However, these issues are likely to gain prominence in the coming years and will need to be addressed to ensure that Ireland meets its obligations under the UN Convention.

7.2 Mission statements

All modern organisations have mission statements which express their purpose and set the culture of the organisation, inform strategic development and help to establish goals against which to measure the progress and success of the organisation. Mission statements in health and social care organisations are particularly important in communicating the purpose of the organisation to service users, staff, and external stakeholders. They communicate the values and principles underpinning the work of the organisation and these are generally regarded as fundamental to successful leadership⁹³. In healthcare, these values or principles might, for example, acknowledge the commitment of the organisation to serving the needs of patients by providing the highest possible level of care. Involving employees in developing a shared vision and principles for an organisation is also considered helpful in uniting people in the organisation behind that shared vision of what the organisation is about.

Crucially, the mission statement also effectively sets out the fundamental values which underpin the relationship between the organisation and the service user, and between the organisation and the State that funds it. In other words, through the mission statement, the organisation is making clear to its service users, funders, and the public what type of organisation it is.

We considered whether there is a difference between a faith-based voluntary organisation (in receipt of state funding for the provision of health and social care) that sets its mission in a religious context and follows its own ethical code, and an equivalent secular voluntary organisation.

There are many common elements in the mission statements we examined such as respect for the dignity of the individual and commitment to the highest standards of care and compassion. However, each organisation expresses its mission statement in a different way, as shown in the following examples.

Some faith-based organisations express their mission statement in a religious context, as can be seen in the following example:

Brothers of Charity

“Belonging to an internationally active movement and rooted in the values of the Christian Gospels, the Brothers of Charity Services Ireland provides quality services to support people who are in danger of being marginalised and strives to create opportunities and choices that develop and maintain connected lives where all are cherished as valued and equal citizens in our communities.”⁹⁴

93 Establishing Values-Based Leadership and Value Systems in Healthcare Organizations, David R. Graber and Anne Osborne Kilpatrick, *Journal of Health and Human Services Administration*, Vol. 31, No. 2 (Fall 2008), pp.179-197.

94 http://www.brothersofcharity.ie/mission_statement.php, accessed 23 July 2018.

Some faith-based organisations make no explicit reference to their faith-based background and set their mission and values in a more secular context, as shown in the following example:

Marymount University Hospital and Hospice

“In providing excellent care, we cherish the uniqueness and dignity of each person, showing compassion and respect. We strive for quality and integrity in all we do.”⁹⁵

This mirrors the mission statements of non-faith-based organisations, for example:

Enable Ireland

“We work in partnership with those who use our services to achieve maximum independence, choice and inclusion in their communities.”⁹⁶

7.3 Issues arising from the ethos of faith-based voluntary organisations

Freedom of conscience and the free profession and practice of religion are guaranteed by Article 44 of the Irish Constitution and by numerous international human rights treaties. These rights include a person’s freedom, in public and private, to manifest his or her religion or belief in worship, observance, practice and teaching. We recognise the need to respect these rights in relation to those who wish to work within, or be treated in, a religious environment, as well as those who wish to work within, or be treated on, a purely secular basis.

Although freedom of religion is widely recognised as a human right, it is also important to note that human rights are not absolute and may be subject to limitations as prescribed by law where necessary to protect public safety, order, health, morals or the fundamental rights and freedoms of others. This is reflected in the text of Article 44 of the Constitution⁹⁷. The difficult issue that arises for states is how to organise their health and social care systems in such a way as to ensure that an effective exercise of religious freedom by health and social care professionals does not prevent or unduly restrict patients and service users from accessing services to which they are legally entitled.

In considering this issue in the Irish context, the areas we identified in which ethical issues might raise questions that should be a matter for public policy were:

- Access to services
- Impact of ethos on patient/service user experience
- Impact on staff recruitment and employment
- Range of lawful services provided

⁹⁵ <https://www.marymount.ie/about-us/about-us-2/>, accessed 26 September 2018.

⁹⁶ <https://www.enableireland.ie/about-us>, accessed 23 July 2018.

⁹⁷ Bunreacht na hÉireann (Constitution of Ireland, enacted in 1937), Article 44.2.1° reads “Freedom of conscience and the free profession and practice of religion are, subject to public order and morality, guaranteed to every citizen”.

These are discussed in the following sections.

7.3.1 Access to services

All of the organisations we spoke to in the course of this review stated that their services are available to anyone who needs them, irrespective of whether they have particular beliefs or none. We did not observe any evidence to refute these statements.

In our public consultation, we asked whether voluntary organisations receiving state funding should be required to state explicitly that their services are open to those of all faiths and none irrespective of the ownership of the organisation: 77% of respondents replied that they should and 12% that they should not be so required⁹⁸. In the interests of openness, transparency and the maintenance of public trust, we consider that all voluntary organisations should state clearly in their mission statements that their services are available to persons of all faiths and none.

Recommendation 7.1

Inclusive mission statements

All faith-based state funded voluntary organisations should state clearly in their mission statements that their services are available to those of all faiths and none.

7.3.2 Impact of ethos on patient/service user experience

In relation to the quality of care provided to service users we did not come across any evidence of difference on the grounds of ethos. Service providers and State bodies across the sector, including in the HSE and HIQA, stated that there was no difference in the quality of care received by patients in voluntary hospitals owned by religious orders and those which are not faith-based.

In our public consultation, we asked people whether, in their experience of care in a faith-based health or personal social care organisation, the religious ethos of the organisation was apparent. Thirty-two respondents felt that it was apparent and twenty-four felt it was not. Of those who felt that the religious ethos was apparent, views were almost evenly split between those who felt it had a positive impact on care provided and those who felt it had a negative impact⁹⁹. For example, those who felt that the religious ethos had a positive impact on care said that it provided a caring, considerate and compassionate environment. One respondent who felt it had a negative impact on care expressed discomfort due to religious celebrants delivering pastoral care. Two organisations working with people with disabilities felt that religious ethos had a negative impact on aspects of service provision relating to sexual health and reproductive services and education of service users.

A number of people who responded to the consultation felt that the religious ethos of an organisation was apparent in its décor, through the presence of chapels, religious icons, logos and posters. While not directly related to the range or delivery of services, we recommend that organisations should be cognisant of the impact of décor on patients/service users and strive to ensure that their personal preferences in this regard are met to the greatest extent possible.

⁹⁸ 11% answered 'Do not know'. See Department of Health website for the report on the public consultation.

⁹⁹ See report in 2018 Consultations, www.health.gov.ie/consultations.

Recommendation 7.2	<p>Religious décor</p> <p>Voluntary organisations in receipt of state funding should be cognisant of the impact of décor on patients/service users and strive to ensure that their personal preferences in this regard are met to the greatest extent possible.</p>
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7.3.3 Impact on staff recruitment and employment

In relation to possible impact on staff, organisations we consulted indicated that their staff come from many faith backgrounds as well as those with no religious affiliation and that the faith-based background of the organisation had no impact on staff recruitment or employment. We did not observe any evidence of breaches of employment equality legislation.

7.3.4 Range of lawful services provided

There is one clear area of potential difference between faith-based and secular voluntary organisations: the issue of refusal to provide certain lawful services on grounds of ethos or conscientious objection. This may be considered to be predominantly an issue in the acute hospital setting but it is also relevant in other areas of health and social care. The ethos of an organisation can lead it to oblige its employees to refuse to provide certain services which are lawful in the State. These could include, for example, termination of pregnancy, aspects of end of life care¹⁰⁰, and issues relating to sexual health and reproductive services, including for people with disabilities. This issue has come into sharp focus in Ireland following the outcome of the 2018 referendum on the repeal of the 8th Amendment to the Constitution¹⁰¹ and the decision to relocate the National Maternity Hospital.

In considering this issue further, we looked at the practical impact of ethos in relation to the availability of services. Given the historical dominance of the Catholic Church in the provision of health and social care in Ireland, we concentrated on Catholic-owned organisations. Although each Catholic-owned hospital has its own Board to make decisions as to what services may be provided in the hospital, there are some services which, if provided in those hospitals, would be inconsistent with the teaching of the Catholic Church. This is clear from the Irish Catholic Bishops Conference's Code of Ethical Standards for Healthcare¹⁰² which was published in June 2018. This Code states "*...Catholic healthcare organisations may at times be asked to provide services not in keeping with the Church's moral teachings*"¹⁰³. The Code goes on to state that "*no healthcare facility or practitioner should provide, or refer a patient for an abortion, i.e. any procedure, treatment or medication whose primary purpose or sole immediate effect is to terminate the life of a foetus or of an embryo before or after implantation*"¹⁰⁴. The Code is not solely applicable to termination of pregnancy, but would also be relevant in the provision of other healthcare services such as contraception, sterilisation, assisted human reproduction, access to clinical trials, genetic testing etc.

100 For example, issues may arise in this context in relation to giving effect to the provisions of legislation such as the Assisted Decision-Making (Capacity) Act 2015 which provides for refusal of treatment and advance directives.

101 Thirty-sixth Amendment of the Constitution Bill 2018.

102 Code of Ethical Standards for Healthcare, The Consultative Group on Bioethics and the Council for Healthcare of the Irish Catholic Bishops' Conference, June 2018.

103 Ibid., pg 26.

104 Ibid., pg 53.

On the one hand, the State has an obligation to organise its health and social care services to ensure access to lawful services by all its citizens and health and social care organisations are obliged to comply with Irish law irrespective of their religious affiliation. On the other hand, Article 44.2.5 of the Constitution protects the right of every religious denomination to manage its own affairs. The interpretation of the extent of this autonomy in the healthcare context has not yet been determined by the Irish Supreme Court. This issue lies at the heart of whether an independently owned, state-funded health or social care service can legitimately refuse to provide certain services and, if so, what are the consequences for both the organisation and the State. We examine this issue in detail in the next section.

7.4 Funding and provision of services

As explained earlier in this report, the roles of the State and faith-based voluntary organisations have been intertwined for many years, making the separation of the roles of the State and the Church less transparent than in several other EU countries with similar historical backgrounds. In practice, this opaque situation has resulted in the state funding hospitals that have retained a degree of autonomy to decide what services they will provide. This contrasts with the practice in other EU countries where the State decides the services it deems essential for the population based on need and then commissions them from a range of private and voluntary organisations or delivers them directly through the public health system.

There are many reasons why all possible lawful services are not available in every hospital in the country, such as cost, population needs, the requirement for specialist skills and teams, as well as decisions to concentrate certain services in centres of excellence (e.g. trauma and cancer care). In addition, not all services are provided in hospitals; many services are provided in specialist clinics or primary care.

Given the position taken by the Irish Catholic Bishops Conference in their Code of Ethical Standards for Healthcare¹⁰⁵, the issue of refusal to provide certain services may arise in Catholic-owned voluntary organisations in cases of procedures such as contraception, assisted human reproduction, genetic testing, access to clinical trials, termination of pregnancy and sterilisation. In the event of a hospital refusing to provide lawful services, assuming that it would otherwise have the capacity and the trained staff available to carry out these services, the question arises of whether any state funding should be available for that hospital for other services it provides.

The full extent of the constitutional right of independently owned faith-based organisations to manage their own affairs has not yet been determined in the healthcare context by the Supreme Court. However, the State has an obligation to organise its health and social care services to ensure access to lawful services by all its citizens. Furthermore, health and social care organisations are obliged to comply with Irish law irrespective of their religious affiliation. Therefore, the State is legally entitled to attach reasonable conditions to any funding it provides and is free not to provide funding to organisations that refuse, on ground of ethos, to provide certain lawful services. Such a decision is essentially a political rather than a legal one due to the fact that, given the significant level of services provided by Catholic hospitals in Dublin, Cork and Limerick, a decision not to provide any state funding to such hospitals would entail serious and prolonged disruption to the health service with consequent detriment to service users and the public. Although we agree on the State's right not to fund organisations that opt out of providing lawful services, we recommend avoiding the serious consequences that could ensue from such a decision.

¹⁰⁵ Ibid.

In reality, the State would not be in a position to replace the extensive range of services currently provided by Catholic organisations, even over a period of many years. Consequently, the State should consider a range of factors in this context such as the extent of services currently provided by faith-based organisations, the scarcity of other providers, the feasibility of providing equivalent services in public hospitals or of new providers entering the sector, the length of any transition and so on.

Taking these considerations into account, we examined whether solutions could be found which would enable all citizens to access all lawful state funded services. In general terms, our Recommendation 8.1 outlined in the next chapter that the State should decide on a list of essential services to be provided to the population and commission them on the basis of a nationally fixed price, together with Recommendation 6.3 on the protection of future State investment in capital assets, would go a long way to resolving the problem. The State would no longer fund providers of services as such but would pay only for the services it deems necessary to meet its obligations to the population. A variety of organisations would then contract to provide a range of services according to their capacity and other considerations and on the basis of quality and safety standards set by the State. Those that do not wish to participate in the provision of certain services, including on grounds of ethos, could decide not to tender for them. However, the State would remain obliged to ensure that the full range of lawful services are available as close as possible to the location of the service user, taking into account considerations of patient safety and clinical expertise/specialisation. The State can always commission the services it decides are needed from the public, private and secular voluntary sectors if local faith-based organisations do not tender for or are not licensed to provide specific services.

We looked at two situations to illustrate this principle:

- How could the full range of reproductive healthcare be provided in Ireland?
- What should happen in emergency situations?

7.4.1 The provision of reproductive health services

The provision of reproductive health services is fundamental to all modern health systems. Our remit asked us to consider any particular issues arising in connection with the provision of services through religious or faith-based organisations so we considered the extent to which reproductive health services might be affected by the religious or faith-based organisation in which they might be provided. While 2 of the 19 hospitals providing maternity services in the State¹⁰⁶, namely the National Maternity Hospital and the Rotunda Hospital, have religious involvement in their governance arrangements (see Appendix 3), this does not appear to restrict the range of services they provide.

However, it is clear that there will be situations (emergency situations are considered separately in the next section) where, for example, it may be necessary to carry out terminations in acute (non-maternity) hospitals. There are 7 Catholic voluntary acute hospitals in the State and these are located in Dublin, Cork and Limerick. In each of these three cities, there are a number of other hospitals and it should therefore be possible for the State to procure or provide the necessary services in the same areas to ensure service user choice and access to all lawful services. Situations where it may not be safe to transfer a patient/service user are dealt with in Section 7.4.2.

¹⁰⁶ There are 4 dedicated maternity hospitals, 3 of which are voluntary organisations. 19 hospitals in total provide maternity services.

Other countries have identified the provision of reproductive services as an issue and have come up with different solutions (see Chapter 4). In England, it is individuals rather than institutions who may conscientiously object to providing these services¹⁰⁷. In Ontario, Canada, hospitals are not required to provide services contrary to their ethos. Similarly, in France private hospitals may refuse to provide terminations of pregnancy. However, it is important to note that French law prevents hospitals with public contracts from refusing to provide terminations if other establishments are not available to respond to local needs¹⁰⁸.

The principles of patient choice and right of access to all lawful services and procedures appropriate to that person would also require that any organisations that refuse to provide certain services have the obligation to provide service users with information on the full range of choices available to them in the State, and where they can be provided with these services. In addition, information on where all lawful services are available should be provided by the HSE in each healthcare region. To give full effect to service user rights and to enable the safe transfer of care, organisations will need to ensure that the relevant patient records are made available without delay. Although a faith-based organisation may claim that providing such information is contrary to its ethos as it facilitates the patient in obtaining the service, patient information and choice are so integral to patient care that we recommend that the right to information should be paramount.

Recommendation 7.3

Access to information and services

- i. The State should provide full information about the availability of, and timely access to, all lawful services as close as possible to the location of the service user.
- ii. All organisations, including any that decide not to provide certain lawful services on grounds of ethos, should ensure that they provide service users with adequate information on the full range of services available in the State and how and where to access such services.
- iii) All organisations should make available all relevant patient records to ensure the safe and timely transfer of care.

107 J. Quigley and J. Long, *Governance of voluntary health and social care providers – England and Canada*, Health Research Board, 2018, European Observatory on Health Systems and Policies, evidence briefing event held in Dublin, 18 June 2018.

108 Article L2212-8 of the Code de la santé publique (available at https://www.legifrance.gouv.fr/affichCodeArticle.do?sessionId=2547E79615907ED36B5805711705BC31tplgr28s_1?idArticle=LEGIARTI000033865551&cidTexte=LEGITEXT000006072665&dateTexte=20180924&categorieLien=id&oldAction=&nbResultRech=) sets out that "A private health facility may refuse to have abortions performed on its premises. However, this refusal can only be refused by a private health institution authorized to provide public hospital service if other institutions are able to respond to local needs." However, Article R.2212-4 of Décret n°2003-462 du 21 mai 2003 relatif aux dispositions réglementaires des parties I, II et III du code de la santé publique (available at https://www.legifrance.gouv.fr/affichTexte.do?sessionId=2547E79615907ED36B5805711705BC31tplgr28s_1?cidTexte=JORFTEXT00000412528&dateTexte=20020505&categorieLien=id#JORFSCATA00000913632), sets out that "The public establishments defined in articles L. 6132-1, L. 6132-2, L. 6141-1 and L. 6141-2 which have beds or places authorized in gynaecology-obstetrics or in surgery may not refuse to practice voluntary interruptions of pregnancy."

7.4.2 Emergency procedures

In emergency cases, the life and well-being of the patient must always be the priority of the medical team and they must make a clinical judgement on the type of treatment and location of treatment according to the assessed situation of the patient. The Guide to Professional Conduct and Ethics for Registered Medical Practitioners¹⁰⁹ states clearly

“49.1 You may refuse to provide or to take part in the provision of lawful treatments or forms of care which conflict with your sincerely held ethical or moral values.

49.2 If you have a conscientious objection to a treatment or form of care, you should inform patients, colleagues and your employer as early as possible.

49.3 When discussing these issues with patients, you should be sensitive and considerate so as to minimise any distress your decision may cause. You should make sure that patients’ care is not interrupted and their access to care is not impeded.

49.4 If you hold a conscientious objection to a treatment, you must:

- *inform the patient that they have a right to seek treatment from another doctor; and*
- *give the patient enough information to enable them to transfer to another doctor to get the treatment they want.*

49.5 If the patient is unable to arrange their own transfer of care, you should make these arrangements on their behalf.

49.6 In an emergency, you must make your patient’s care a priority and give necessary treatment.”

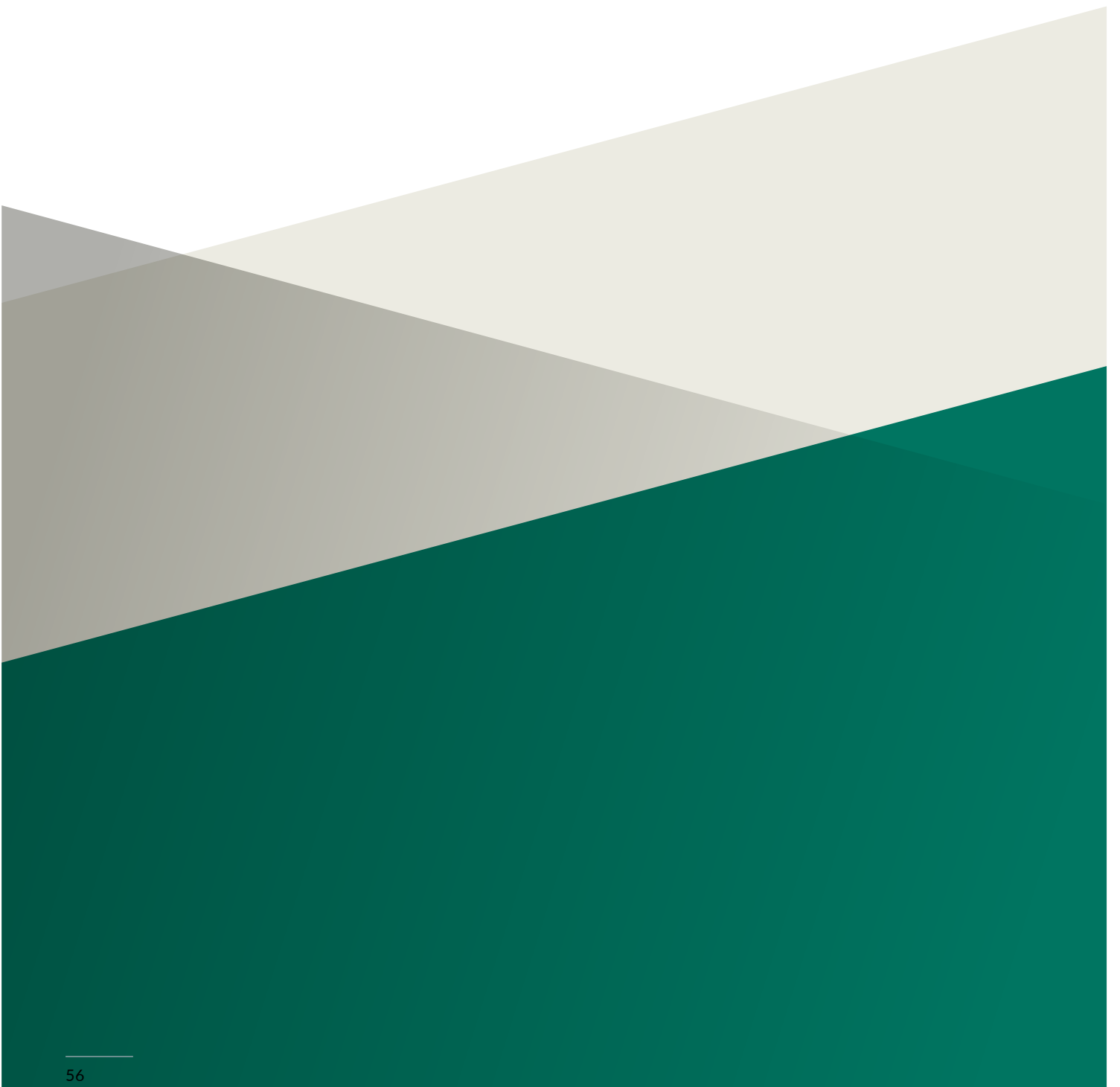
Thus, healthcare professionals should be free to decide on the appropriate treatment in accordance with best practice and the wishes of the patient, even in situations where such treatment is not normally available at that hospital. In emergency situations, the life and well-being of patients must always take precedence over the ethos of the organisation and therefore organisations must ensure that all legally permitted treatment is made available to the greatest extent possible within the capabilities available to the hospital.

Recommendation 7.4

Emergency situations

In emergency situations, the life and well-being of patients must always take precedence over the ethos of the organisation and therefore organisations must ensure that all legally permitted treatment is made available safely to the greatest extent possible within the capabilities available to the organisation.

¹⁰⁹ Guide to Professional Conduct and Ethics for Registered Medical Practitioners, Medical Council, 8th ed., 2016, available at <https://www.medicalcouncil.ie/News-and-Publications/Reports/Guide-to-Professional-Conduct-and-Ethics-8th-Edition-2016-.pdf> accessed 24 September 2018. The IRG notes that the Medical Council has begun a process to review the Guide to Professional Conduct and Ethics.



8 Relationship between voluntary organisations and the State

As set out in Chapter 5, we believe the voluntary sector will continue to play an important role in the provision of health and social care services in the coming years. That being the case, it is important that there is an effective and mutually respectful relationship between the State and voluntary organisations. Our mandate also asked us to consider how this relationship should evolve in the future. It is clear to us that the relationship at present is fractured and needs to be placed on a new footing.

Having looked at the situation in other countries with a similar background in terms of involvement of the voluntary sector (see Chapter 4), we take the view that better results could be obtained by having a clearer national regulatory framework on certain key components of a modern healthcare system. For example, a system based on licensing would ensure national safety and quality standards. An enhanced model of service planning, based on a national list of essential services with agreed tariffs and an appropriate framework of performance and accountability, would provide the basis for a more effective relationship between the State and voluntary organisations. It would enable more focus on the quality of services and outcomes delivered rather than financial and control aspects. It would also ensure equality of access to services across the country. This type of national framework would enable care organisations to have more autonomy in how they deliver the required services at local level and would also ensure neutrality at the point of delivery. We believe that enhancements to the current model of service planning and funding will be fundamental to evolving the State-voluntary relationship over the medium term so we address this first.

We then considered a range of issues that were raised during our discussions with stakeholders and we set out a number of recommendations for improving the relationship in the short term.

8.1 How services are commissioned

The HSE currently funds services through Service Arrangements (SAs) with providers (in addition to those services which it provides directly and a small proportion of services that are procured by direct tendering). The process for this is outlined later in this Section. However, in practice the current process seems to be mainly based on historic block grants, and in the acute sector through the use of activity based funding (ABF), rather than on meeting the requirements of patients and service users which have been objectively assessed.

As outlined in Chapter 4, it is common practice in other countries for the state to develop a list of essential services that will be commissioned by the state for an agreed price, usually based on independent costings. The list of essential services and the cost of providing these services are often established in consultation with the voluntary sector.

There have been efforts over the years to put in place more formal arrangements for funding services and for service planning and monitoring of performance and accountability. As part of the Future Health

Strategy¹¹⁰, a complete restructuring of the health service was envisaged with the dismantling of the HSE, the introduction of a formal purchaser/provider arrangement, the creation of a commissioning agency, and new hospital and community care structures. While these proposals have not been pursued, a number of initiatives have been introduced that would assist a move toward a commissioning approach, or at a minimum an enhanced form of planning and funding services as opposed to simply funding providers. These include the roll-out of ABF for inpatient and daycase services in the acute sector and efforts to establish a mechanism to cost community services.

Moving to funding agreed essential services would have several advantages. For example, it would rightly put the focus on the needs of the service user and on the quality of services provided by different providers. In the disability sector it would fit with the human rights approach of the UN Convention on the Rights of Persons with Disabilities¹¹¹. It would also be part of the necessary cultural change from a medical/institutional/segregated approach to people with disabilities to more person-centred, individualised support in the community.

A critical requirement in the implementation of such a scheme will be the introduction of a comprehensive, robust regulatory mechanism to ensure that services are delivered safely and in compliance with associated national standards.

Recommendation 8.1	<p>List of essential services</p> <ul style="list-style-type: none"> i. A list of essential services to be funded by the State should be agreed in consultation with the voluntary sector. ii. Full cost prices for delivery of these services should be agreed centrally. iii. The list should be updated regularly, with provision for adjustment to meet local circumstances. iv. Appropriate national standards should be developed for services in the list of essential services, where these do not already exist. Organisations that provide these services should be robustly monitored by the appropriate agency to ensure their compliance.
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These changes will take time to implement since agreeing a list of essential services will require comprehensive, accurate data on population needs, building up data on unit costs to enable accurate budgeting etc. The 2012 report on 'Value for Money and Policy Review of Disability Services in Ireland' highlighted many problems of lack of data and made several recommendations for improving the depth and comparability of data needed to support policy making, monitoring and performance follow-up¹¹². There is a need to improve data collection on physical and sensory disability and involve service providers and support organisations in such an exercise¹¹³. Current capacity constraints will be exacerbated by likely future demand pressures so better forward planning based on good data is needed.

110 <https://health.gov.ie/future-health/>

111 UN Convention on the Rights of Persons with Disabilities, available at <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html>, accessed 3 August 2018.

112 Value for Money and Policy Review of Disability Services in Ireland, Department of Health, 2012.

113 This should build on work done under the 'Transforming Lives Programme' to implement the recommendations of the 'Value for Money and Policy Review of Disability Services in Ireland', including recommendations on data in 'Report on Future Needs for Disability Services', Transforming Lives Working Group 1, April 2018.

Good data is an essential requirement for good policy making and delivery. While data systems for hospitals are reasonably well developed, there is a dearth of data in relation to many non-acute services. We recommend that the Department of Health and the HSE undertake a full mapping of all voluntary organisations providing non-acute services under Section 38 and Section 39 of the Health Act 2004, and of their capacity to provide a range of necessary services in the coming years. This mapping should be updated at regular intervals. It could provide useful input to the development of a list of services which are considered “*hard to replace*”, a classification used by the National Health Service (NHS) in England¹¹⁴ to identify services which “*would have to remain in the locality should a provider fail because: a) either there is no alternative provider close enough; or b) removing them would increase health inequalities; or c) removing them would make dependent services unviable*”.

Establishing a “*hard to replace*” list would help the Department of Health and the HSE to plan for continuity of service and to decide in future planning whether to continue to rely on external providers or to move to direct State provision of key services. Steps in this direction can be started now and developed over time. They are in line with the approach set out in the Sláintecare Implementation Strategy, which centres on the development of a population health approach to health service planning and delivery. Key actions in the Strategy include the development of a health service masterplan to inform detailed service planning and resource allocation and the introduction of population-based funding allocations.

Recommendation 8.2

Mapping of service provision by voluntary organisations

The Department of Health and the HSE should undertake a full mapping of all voluntary organisations providing personal social care services receiving public funding, and of their capacity to provide a range of essential services in the coming years. The results of this mapping should be updated and published at regular intervals.

8.2 Relations between the State and the voluntary sector

Since the adoption of the 2004 Health Act, there have been major changes in the control and the scale of funding of Irish health and social care. The HSE is now the main – and often the only – point of contact between the State and the voluntary sector in relation to the funding and provision of services.

The past ten years have been difficult years for everyone in the health service and the need to cut budgets and find economies have left their mark. While the Section 38 organisations criticised some aspects of their relations with the HSE in their conversations with us, most of them are sufficiently large and well-staffed to be able to deal with the heavy increase in bureaucracy that has characterised the development of the SAs which are the main form of contracts between the State and the voluntary sector. In a submission from the Voluntary Healthcare Forum¹¹⁵, they argued that the current SA governance model “*is not designed to accommodate the autonomy, independence or the legal structures of voluntary organisations.*”

114 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/481614/CRS_-_expiry_note_for_commissioners.pdf accessed 2 August 2018.

115 Voluntary Healthcare Forum, June 2018. The VHF represents more than 250 Chairs and Non-Executive Directors of voluntary hospitals from 18 different hospitals. Although the St. Vincent's Healthcare Group is not part of the VHF (because of their unique legal structure) they wrote to us to support the VHF submission.

Most of the Section 39 organisations are smaller and many were vocal in their criticism, which can be summed up as concern for what they see as a ‘command and control’ relationship and a lack of trust and partnership. For example, The Wheel said *“there is a general view that the HSE doesn’t respect what the sector does or value the sector’s work in society”*¹¹⁶. Complaints from Section 39 funded organisations were mostly with regard to the institutional relationship with the HSE. Many organisations stressed their good relationships with individual HSE staff on the ground and at local level. However, there seems to be a problem in the institutional engagement which was also reflected in comments made in the public consultation.

There will always be complaints about bureaucracy, especially in an area where people are passionately committed to the causes they represent. From its establishment in 2005, the HSE has had a difficult path to follow in establishing a national system to manage a complex service under intense political and media scrutiny. However, the pressures of the financial crisis seem to have led to ‘mission creep’ and increased micromanagement by the HSE. In particular, the HSE seems to have used the annual SA negotiations to impose conditions that have eroded the autonomy of voluntary organisations, irrespective of the scale of state funding to an organisation. The obvious need for tighter control over spending seems to have led to the no doubt unintended consequence that almost all of the interaction between the HSE and the voluntary organisations is spent on financial measures and targets, rather than on patient/service user needs and outcomes. However much one can understand the pressures on HSE staff and of the financial crisis, it seems that the relationship has deteriorated and there is an urgent need to place the relationship on a new footing.

A new beginning should start from the mutual recognition of interdependence. The State needs the voluntary sector to continue to provide health and social care. It would be challenging for the State to take over the role of the voluntary sector and it would certainly not be able to provide the same range of personal and personalised services across the country, even in the medium term. Elsewhere in this report we have outlined the added value which the sector brings to health and social care (see Chapter 5). If the State wishes to continue to benefit from the contribution of the voluntary sector, as we believe it should, it needs to recognise this contribution and to build a new and sustainable relationship of trust and partnership with the sector.

Equally the voluntary sector must accept that it is now heavily dependent on public funding to deliver services to its patients/service users. This inevitably brings a reduction in autonomy, increased regulation and scrutiny, the need to accommodate national policy requirements and adhere to national standards, and to be more closely integrated into a network of regional services requiring it to share data and make systems interoperable.

The challenge therefore, is to find an appropriate balance between the necessary control by the State and the autonomy and legal independence of the voluntary sector so it can continue to deliver agreed services in ways that enable it to play to its strengths.

8.2.1 Principles to inform the future relationship between the State and voluntary organisations

Building on several previous reports on the voluntary sector, on the results of our public consultation and the many views we received, we consider that a number of principles should guide a new beginning and future interaction between the State and the voluntary sector. This new relationship could be set out in

¹¹⁶ The Wheel, Submission to the Review Group examining the role of voluntary organisations in publicly funded health services, May 2018.

a Charter on the value and role of the voluntary sector in delivering health and social care¹¹⁷ and include the following principles:

- **Shared purpose, putting the patient/service user at the centre:** The State and the voluntary sector should agree that their shared purpose is the delivery of the best possible health and social care for the population, including by moving towards person-centred care and away from focusing on the service provider.
- **Official recognition:** The State should recognise the legally separate status and public service value of the voluntary sector and express its commitment to working with it, in a spirit of partnership and trust, in the delivery of health and social care services. Consideration could be given to renaming these organisations public benefit or not-for-profit organisations as part of recognising their legally separate and distinct status.
- **Active partnership, involvement and dialogue:** Official recognition should be given active meaning through a State commitment to involve and consult with the voluntary sector at an early stage in the development of all relevant policy initiatives, strategic developments and structural changes. This could be done by bringing together the different State bodies involved in the health and social care sectors and the voluntary sector, perhaps as a Forum. This could bring together existing bodies or be a new entity and would fit well with the emphasis on “deep and sustained engagement with stakeholders” as set out in the Sláintecare Implementation Strategy. There should be a core membership comprising the Department of Health, HSE, HIQA and representation from the voluntary sector, and involvement from other Government Departments (such as Employment Affairs and Social Protection, Education and Skills, and Transport, Tourism and Sport) and State agencies and regulators as required. This Forum should consider the establishment of implementation sub-structures, if required, for example in order to provide a more co-ordinated cross departmental service to individuals in need of different State services at different stages in their lives.
- **System approach:** Public and voluntary organisations are both integral components of the Irish public health system. While local innovation and flexibility must be encouraged and promoted, organisations must also operate within nationally agreed financial, regulatory and policy frameworks to ensure the most effective delivery of health and social care services.
- **Governance:** The State and the voluntary sector should agree a set of governance principles which are broad enough to cover the needs of large voluntary hospitals as well as small, local personal social care organisations but which would be adaptable to the specificities of each organisation¹¹⁸. The Forum would provide a useful structure for considering such governance principles, in line with recommendations in Chapter 6.
- **Support and training:** A support function should be created and publicly funded to help the voluntary sector, especially smaller organisations, have access to training (for their staff and their Boards) and shared legal, accounting and other services. Such a function could also support

¹¹⁷ It should take into account wider developments relating to the community and voluntary sector, such as the implementation of the Framework Policy for Local and Community Development in Ireland.

¹¹⁸ This could draw on the work already done on the key elements of a good governance code – for example, the Governance Code – A Journey to success, A Code of Practice for Good Governance of Community, Voluntary and Charitable Organisations in Ireland (<http://www.governancecode.ie/>) and also Report of the Consultative Panel on the Governance of Charitable Organisations, 5 April 2018 available at <https://www.charitiesregulator.ie/media/1389/report-of-the-consultative-panel-may-2018.pdf>.

training of HSE and other public servants in dealing with the voluntary sector. The Sláintecare Implementation Strategy highlights the need to build leadership and organisational capacity in the Department of Health and the HSE to help meet the challenge of implementing Sláintecare. There is a similar need in the voluntary organisations, particularly the smaller ones, which they are unlikely to be able to meet from their own funds.

For the most part these are not new ideas. A considerable amount of work has gone into defining principles and the role of the voluntary sector in the past but no recent attempt to put the role of the voluntary sector on a firm footing has been brought to a satisfactory conclusion. Now is a good time to build on that past effort and to find a way to give public recognition to the substantial contribution that the voluntary sector makes to health and social care services in Ireland.

Recommendation 8.3

Official recognition through a Charter

A Charter should be drawn up to give official recognition to the legally separate status of the voluntary sector and to reflect its public service role in the provision of health and social care services. The Charter should be developed and agreed with the voluntary sector and adopted within a twelve-month period.

Recommendation 8.4

A new Forum

A Forum should be established to facilitate regular dialogue between the relevant State representatives and the voluntary sector to ensure their full involvement in future policy and strategic developments.

8.3 Contractual relations

Public money must be spent in a transparent and accountable way and with a view to getting the best possible value for money. However, controlling how that money is spent also carries a cost. Many Section 39 funded organisations told us they felt the burden of administration associated with state funding was disproportionate and that it diverted staff and funding resources away from patient/service user activities. Clearly the cost to the State of tracking the use of amounts as low as €200 and even less is many times the amount spent so it seems to us that a more proportionate approach is needed.

At present, the HSE enters in to an SA with all Section 38 and 39 organisations that receive over €250,000 in annual funding. For those organisations that receive under €250,000 a significantly less onerous Grant Aid Agreement is used¹¹⁹.

The HSE conducts annual negotiations with each Section 38 and Section 39 organisation and these are often the only central point of contact between these organisations and the HSE. These negotiations usually culminate in the signature of an SA between them. The use of Service Level Agreements or Service Arrangements by public authorities is in keeping with international practice. No one contests the need for transparency and accountability where the State is paying for services to be delivered by non-State organisations. However, there is a need for to avoid excessive and costly bureaucracy which can negatively influence the delivery of the services being contracted and draw resources away from the actual delivery of services – both for the State and the provider.

In the meetings we held, and in the many submissions we received, widespread concern was expressed about the burden of the contractual relationship with the HSE and with the way in which negotiations are conducted. In fact, most voluntary organisations said that the process could not be accurately described as a ‘negotiation’ at all.

The SAs have become very burdensome as they have evolved. They have become the carrier of an ever-increasing number of obligations and conditions, many reflecting administrative reactions to specific problems. In its June 2018 submission to us the Voluntary Healthcare Forum wrote that *“there is a lack of adequate and meaningful consultation in the (SA) process for securing agreement about the SA requirements with individual organisations. The process does not take into account unique experiences of individual service providers, such as their national specialities. Increasingly the SA has become ‘an imposed contract’ which in many cases causes significant challenges for service providers”*¹²⁰. There seems to be a tendency for the HSE to treat the voluntary sector as though it was part of the statutory system without taking sufficiently into account the separate legal status and private ownership of these organisations.

The SAs also entail a heavy burden for the HSE. By way of illustration, Table 9 shows the number of Review Meetings the HSE would need to conduct to meet the recommended frequency set out in its governance framework for Section 38 and Section 39 organisations – 1,462 meetings in total.

119 All Section 38 organisation receive much greater amounts than €250,000 so Grant-Aid Agreements only apply to the smaller Section 39 organisations.

120 Voluntary Healthcare Forum. Submission to the Review Group examining the role of voluntary organisations in publicly funded health services June 2018.

Funding level to agency	Recommended review meeting frequency	No. of voluntary organisations	Total recommended no. of review meetings
Over €40 million	10 times per year	21	210
€20 million - €40 million	6 times per year	16	96
€5 million - €20 million	4 times per year	38	152
€1 million - €5 million	3 times per year	114	342
€250,000 - €1 million	Twice per year	156	312
€50,000 - €250,000	Once per year	350	350
Less than €50,000	Documentation control - once per year	1,436	n/a
Total number of Review Meetings needed to meet recommended frequency			1,462

Table 9 - Number of recommended HSE Review Meetings per annum

Control is necessary but effective control depends more on the nature of the engagement and the relationship established than on the number of meetings. It gives the appearance on paper of stringent control but in practice it can create heavy bureaucracy without meaningful engagement.

While the model of service planning and funding is being enhanced and a move to a list of essential services is being developed over the medium term, there are a number of short term recommendations in relation to the current SA process that could help. This includes the development of a revised SA based on the size of the annual funding allocation – for example, based on the following groupings:

- over €20 million,
- from €5 million to €20 million,
- from €250,000 to €5 million,
- from €1,000 to €250,000, and
- below €1,000.

The aim would be to have a streamlined process with a more central focus on the services being delivered. The HSE already applies a lighter control system to grants below €250,000. However, we consider that further streamlining is merited in the short term and would help to focus staff resources on the quality of services provided rather than on template procedures.

The HSE should engage with voluntary organisations to establish control procedures that will be more effective and less bureaucratic for all parties, whilst still ensuring necessary oversight of significant expenditure by the State. The new arrangements should focus on the services to be delivered in each regional area and minimum standards to be met, the quality of the services delivered and the performance of the provider. They should also include the re-use of financial and other information already provided to other arms of government (for example, to the CRO and Charities Regulator). New arrangements should

be applied on a trial basis, for example three years, and, at the end of that time, an evaluation should be carried out to see if the simplified version has given rise to any problems and/or benefits and whether further simplification can be made, in the light of actual performance.

For very small amounts of funding, for example less than €1,000, we consider that it may be sufficient to have a very simple procedure without follow-up required. If a subsequent application for a similar level of funding is made then a report on the outcome of the previous funding could be required.

Recommendation 8.5

Revision of Service Arrangements and Grant Aid Agreements

Working groups composed of representatives from the Department of Health, the HSE and voluntary organisations should be established, according to level of funding received, to review and simplify the Service Arrangements and Grant Aid Agreements with a view to introducing new arrangements by 2020. New arrangements should be applied on a trial basis and subject to an evaluation after the trial period.

8.4 Information requests

Many organisations, both large and small, expressed considerable frustration with receiving repeated requests from different units/sections of the HSE for the same or similar information which had already been supplied – and frequently within a very tight deadline.

We were told by a number of providers that such ad hoc requests for information (beyond the requirements of the SA or Grant Aid Agreement) appear often to be in response to pressure on the HSE to provide information in order to respond to, for example, Freedom of Information (FOI) requests or Parliamentary Questions. It is therefore understandable that it may be necessary in certain circumstances to pass on these requests to the individual providers. However, in the absence of comprehensive IT systems in the smaller voluntary organisations or indeed in the HSE itself, the cost of these requests needs to be recognised. Ultimately, they consume resources which could be spent on the provision of front line services. There is an onus on the HSE to check first that it does not already have the information before passing the request on to the provider.

The Report on the Accounts of the Public Services by the Comptroller and Auditor General¹²¹ noted that in certain circumstances “*it is unclear what information is actually being sought by the HSE*” from providers. This might help to explain why the report also noted that many agencies were failing to submit information requested by the HSE and that this was not being followed up by the relevant CHO. This situation is unsatisfactory and runs the risk of violating Data Protection Principle 6 which requires data controllers (in this case, the HSE) to ensure that the information they collect is “*adequate, relevant and not excessive*”¹²².

121 Report on the Accounts of the Public Services 2016, Comptroller and Auditor General, September 2017, available at http://www.audgen.gov.ie/documents/annualreports/2016/report/en/Report_Accounts_Public_Services_2016.pdf, accessed 17 July 2018.

122 <https://www.dataprotection.ie/docs/The-Data-Protection-Rules/y/21.htm>. Accessed 15 July 2018.

The HSE could do more to adopt the best practice information principle of ‘collect once, use many times’. Information should be requested only once and it is the HSE’s responsibility to ensure that, where necessary, it is appropriately shared across the organisation (and in compliance with data protection legislation). We note that the HSE is in the process of establishing a Contract Management Support Unit within each of the CHOs. This Unit should become the single point of contact for all provider request information and should be responsible for maintaining a shared information directory about providers. Many organisations receive funding on an annual basis and there should therefore be no need to provide the same basic information about their organisation each time.

A second issue relating to information which arose during the course of our work concerns the duplication of requests for information which has already been provided to other State bodies. Information is a valuable resource which is expensive to collect, store and manage. This is wasteful and represents a burden in terms of time and resources, both for the State and for the organisations required to provide the information. Arguably of even greater concern, is that we found evidence which would suggest a lack of trust among the various State bodies which leads not only to duplication of requests for information but also to repeating work which has already been done by another State body. The State should show its confidence in its own appointed bodies to carry out the controls they are required to make. If insufficiencies are identified they should be addressed by adjusting the mandates of these control bodies, not by endless requests for additional information for unclear purposes.

Many other countries have identified this as an issue which needs to be addressed. For example, Australia has introduced the ‘Charity Passport’¹²³ which contains all the Australia Charities and Not for Profits Commission’s publicly available charity information, including financial information. It should be noted that such an approach does not require a common IT system but rather that participating agencies agree to provide their information (export it from their systems) according to an information exchange standard. In this way, data is shared across relevant government agencies reducing the regulatory burden both on the agencies themselves and on the charities and not-for-profits.

Recommendation 8.6

Requests for information

To ensure that information requests are necessary and proportionate, the HSE should develop a set of principles and processes governing information requests to organisations, which adhere to data protection principles and the best standards of information governance.

Recommendation 8.7

Avoiding duplication of requests for information

- i. Requests for information that has already been provided to another arm of the State should be avoided.
- ii. A Memorandum of Understanding should be agreed between the main relevant bodies which would commit them to re-using data already provided to other State bodies.

8.5 Funding

State funding to voluntary organisations in the health and social care sector is channelled through the HSE on an annual basis. It seems that the starting point of each annual negotiation is the amount received in the previous year¹²⁴. This does not allow for any innovation or reform or piloting of new ideas and it may even penalise organisations which have been able to make economies through efficiency gains. Moreover, it does not put patient/service user needs at the centre of negotiations on delivery of services.

Several Section 39 organisations have told us that they are accumulating deficits because they cannot provide the services specified in their SAs for the budget provided. These deficits are not recorded in the SAs and are not provided for in annual funding allocations. If organisations refuse to sign SAs which do not cover their costs, 20% of their budgets can be withheld. In some cases, supplementary funding is provided towards the end of the year to meet accumulating deficits.

In the course of our work, some voluntary organisations have expressed concern about a growing challenge in recruiting new Board members because of difficulties regarding perceived erosion of autonomy, lack of adequate funding and more specifically because of the risk of funding deficits. Some potential members have expressed reservations about joining Boards due to the risk of a shortfall in the funding of the organisation with a consequent potential that it might be found to be trading while insolvent. This could lead to prosecution and imposition of personal liability on Board members for reckless trading under company law¹²⁵.

We did not have the research resources to quantify the extent to which deficits are being built up and to assess the driving force behind these deficits (e.g. under-funding, inefficiencies etc.) but we recommend that the Departments of Health and of Public Expenditure and Reform undertake a survey to measure the extent of the problem. It may not be very big now but it is potentially an avalanche waiting to happen. Once the scale of the problem has been established plans should be made for the absorption of the deficit and/or a reduction in the services provided.

Voluntary organisations have also reported that decisions on their funding are taken too late in the year and that the annual nature of the exercise does not allow for forward planning. Funding for capital expenditure is handled separately and even where capital funding is provided the necessary operational funding (for staff, administration, equipment etc.) is not always integrated, making longer term investment planning very difficult.

In line with practice in other EU countries, we recommend moving to multi-annual budgets. These could be for three years to start with and perhaps later extended to five years. This is consistent with Action 7.2.1 of the Slaintecare Implementation Strategy regarding the development of multi-annual budgeting. On the basis of a list of essential services that the State commits to fund (see Recommendation 8.1) prices for the full cost of providing these services should then be agreed centrally (i.e. including provision for capital and overhead costs).

Recommendation 8.8

Managing deficits

The Departments of Health and Public Expenditure and Reform should undertake a review of the financial position of voluntary organisations that would include an analysis of surpluses/deficits over the last five years and the main drivers and put forward proposals for resolving any deficits identified.

124 For the acute sector, ABF was introduced in 2016 in respect of Inpatient and Daycase activity.

125 Companies Act 2014, Article 610 on civil liability for fraudulent or reckless trading of company.

Recommendation 8.9	<p>Multi-annual budgets</p> <p>There should be a move to multi-annual budgets for 3-5 years in duration to facilitate strategic service planning and reform of services.</p>
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8.5.1 Own funds of voluntary organisations

Although the importance of state funding has increased for almost all voluntary organisations, some still have the possibility to raise funds through fundraising, donations, legacies etc. Legally, the State cannot control these funds but in practice they are used as a form of cross-subsidisation of the services contracted to the State.

If the State moves to multi-annual funding of contracted services on a full cost basis, the question arises of how to treat the independent funds of voluntary organisations. In the spirit of trust and partnership that we recommend in Chapter 8, there should be open and transparent discussion on the financial capacity and financing intentions of the voluntary sector as part of the SA process. Such funds could be used to provide services not covered by the nationally agreed list of services or to cover capital costs which the State either cannot or would not finance.

In the same spirit of trust and partnership, voluntary organisations should share their future plans with the HSE at the earliest possible opportunity. For example, this would be particularly important where a voluntary organisation is considering withdrawing from the provision of some or all of its services. In such cases every effort should be made to put the interests of the service users first and to ensure that appropriate measures for continuity of service can be put in place without undue disruption for the service users.

Recommendation 8.10	<p>Integration of fundraising plans</p> <p>There should be open and transparent discussion on the financial capacity and fundraising plans of the voluntary sector as part of the Service Arrangement process.</p>
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8.6 Need for an appeals process

It is inevitable with any service level arrangement that there will, from time to time, be disputes between the funder and the provider. It is always important to have effective and appropriate dispute resolution mechanisms to ensure issues can be resolved quickly and positive relationships maintained. The current arrangements between the HSE and voluntary organisations include an escalation process for resolving disputes that cannot be dealt with through direct discussion. This is a four-stage process: stages 1 and 2 involve discussion between both parties; stage 3 involves a referral to mediation and stage 4 involves a referral to arbitration. However, the consent of the HSE is required to advance to stage 3 or stage 4, which gives the impression that this process is weighted in favour of the HSE, as it is only on its agreement that the matter can be referred.

The current appeals process is not used often. The HSE informed us that dispute resolution under clause 33 of the Service Arrangement was invoked 11 times in 2017, reaching various stages and with varying outcomes. This may be because there are few problems that cannot be resolved through dialogue or because the system is too onerous or for other reasons. However, we consider that there is a need for an appeals procedure based outside of the HSE so that a third party can help resolve problems between the HSE and voluntary organisations. It should be focused on process issues and should not be drawn into issues such as the negotiation of budget allocations. The Forum proposed in Recommendation 8.4 could be tasked with developing this process.

Recommendation 8.11**Mechanism for resolving disputes**

An independent process should be put in place to resolve disputes (excluding the negotiation of budget allocations) between the HSE and voluntary organisations.

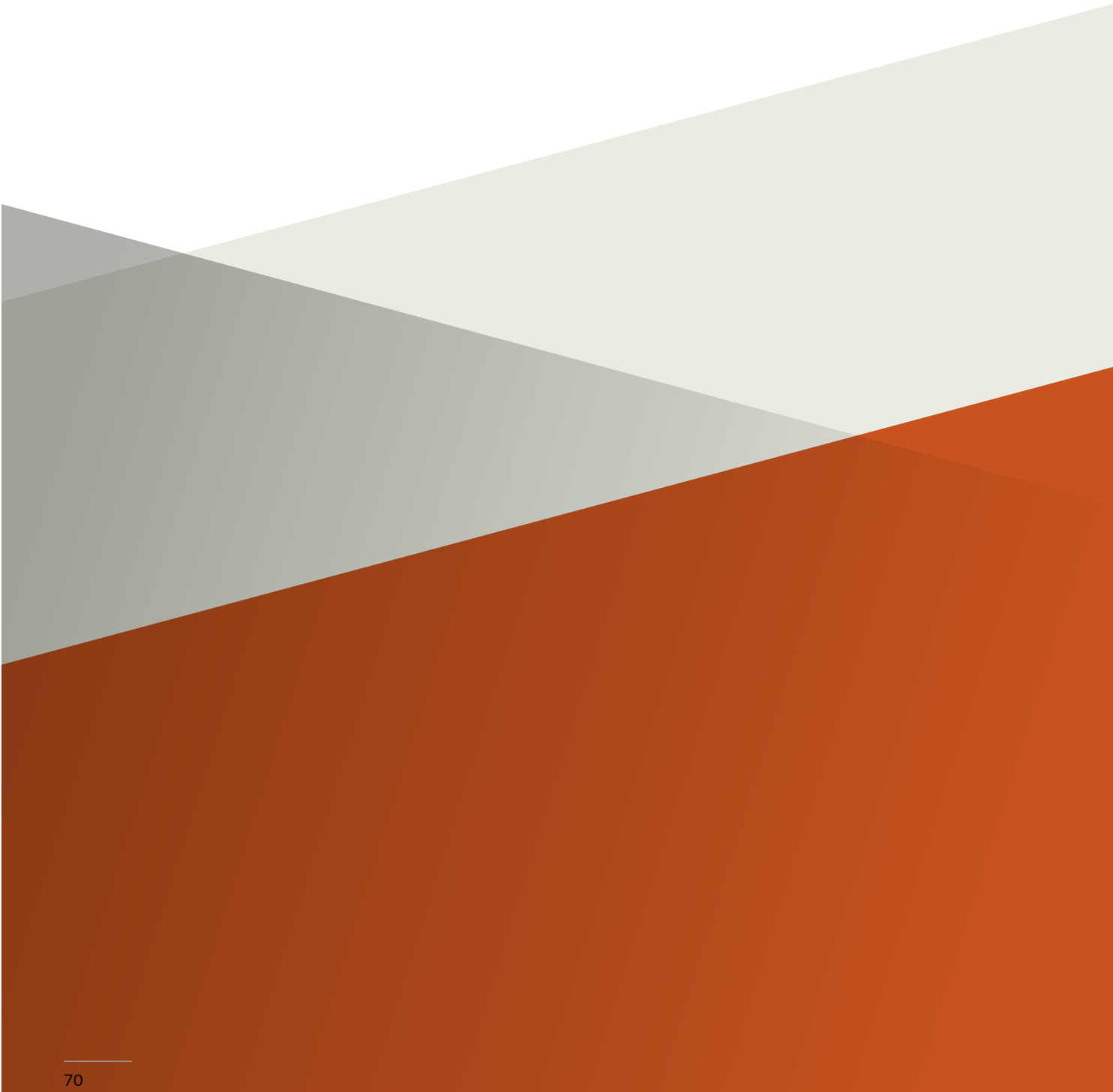
8.7 Role of the Department of Health

In line with many other countries, Ireland has followed the trend of separating policy formulation and strategy from implementation. Thus the HSE, HIQA and others now carry out the functions that were previously undertaken by the Department itself. There are good reasons for this separation but there is also a danger that policy becomes detached from implementation on the ground and that those who are at the front line, implementing policy, begin to develop their own policies. In the end, usually when problems occur, the identification of responsibility becomes blurred and it is harder to make corrections without major upheaval.

In our view, there needs to be stronger accountability of the HSE to its parent department, the Department of Health. The appointment of a new Board will insert an important new level of accountability but ultimately the HSE is an agency of the State and needs to be steered and overseen by it. We recommend that the Department of Health plays a stronger and more visible role in the interface between the HSE and the voluntary sector. This could be developed under the Sláintecare Implementation Strategy commitment to “Define and agree a new organisation and operational structure for the future reconfigured health service, including respective roles of the Department of Health, the HSE and national and regional integrated care organisations”¹²⁶. The Forum that we recommend would help to restore a climate of trust and partnership and to enable a more joined up delivery of services to patients/service users.

Recommendation 8.12**Role of the Department of Health**

The Department of Health should play a stronger role as the parent department of the HSE and in the interface between the HSE and the voluntary sector.



9 Future opportunities

9.1 The place of the voluntary sector in the new architecture of Irish health and social care services

A number of decisions have been taken or are planned which will shape the architecture of Irish health and social care services. Some of these pose challenges for the voluntary sector. Some key aspects of the new architecture are still under consideration so it is difficult to make specific recommendations without knowing how the pieces will fit together. In the following section we highlight some issues that should be taken into account as wider decisions are taken.

9.1.1 Hospital groups

In each of the seven hospital groups there is a different mix of hospital types. There is no voluntary hospital in the Saolta group, while the Ireland East grouping consists of five state-owned and six independently owned voluntary hospitals. At present, the hospital groups are working together on an administrative basis and the Boards of constituent voluntary organisations remain responsible for decisions taken.

A revised set of health structures will be developed over the coming three-year period as part of Sláintecare proposals. This includes the establishment, in time, of regional integrated care organisations which will have responsibility for planning and delivering a broad range of health and social care services. The Sláintecare Implementation Strategy indicates that a decision will be made on the details of the new organisational and operational structure in 2019. This raises questions as to the future of hospital groups and the issue of whether they will be given a statutory remit. It also raises questions around how voluntary hospitals, and indeed, voluntary organisations delivering non-acute services will interact with these new regional bodies and how the independence and autonomy of the voluntary sector can be preserved. Any changes proposed will have an impact on voluntary organisations and it will be important that they are consulted early in the deliberative process.

Recommendation 9.1

Future structures

Voluntary organisations should be consulted fully regarding any future health structures so that a solution is agreed to enable them to retain their separate legal identity and autonomy, while ensuring that the services they contract to provide are part of an integrated concept for the whole region.

9.1.2 Commissioning

The word commissioning is used to describe a wide variety of ways in which the State procures and funds services from non-State organisations. As explained elsewhere in this report, the HSE today effectively commissions services through the Service Arrangement process. However, the HSE is also a provider of services and it is clear from our work that this dual role creates unnecessary mistrust and tension between statutory and voluntary organisations, with each thinking the other receives preferential treatment. We recommend separating the commissioning and service provider roles of the HSE. Our recommendation for a nationally agreed list of essential services to be funded by the State and delivered by different organisations, both public and not-for-profit voluntary organisations, would form the basis for developing an enhanced service planning and funding system and potentially a future full commissioning system.

Recommendation 9.2

Dual role of commissioner/provider

The roles of commissioner and provider of services should be separated.

9.2 Fostering innovation

One of the added values of the voluntary sector historically has been its capacity to innovate, testing new ideas and constantly updating to improve patient/service user care. The funding cutbacks of the crisis years probably had a negative effect on capacity to innovate in both the voluntary and public sectors. We recommend the creation of an Innovation Fund which would award grants on a competitive basis to innovative projects to be carried out in the voluntary and public sectors. Selection criteria should be based on excellence and the potential for extending innovative practices and reform ideas across the healthcare sector. We recommend that the fund be launched with a €20 million capacity to finance grants over a three-year period. It should then be reviewed to assess impact and value for money.

Recommendation 9.3

Innovation fund

An Innovation Fund (initially €20 million) should be created which would award grants on a competitive basis to innovative projects to be carried out in the voluntary and public sectors.

9.3 Joined up government

Many people need to interact with multiple State services in order to receive the health and social care that they need at different stages in their lives. It can be wearying and frustrating to have to deal with many different State services, each handling one aspect of the care needed but with no overall responsibility for providing the integrated package of person-centred measures the individual really needs. The service provided should reflect a cross-government view of how the needs of particular individuals should be met, at every stage in their lives and we consider that the departments most closely involved in providing this overall care should step up their inter-departmental co-ordination and ensure the close involvement of the voluntary sector in bringing about better person-centred results. This would be in keeping with

the vision of integrated care set out in the Sláintecare Implementation Strategy. The Forum we propose (see Recommendation 8.4) could play a role in this process.

9.4 Consolidation

There are approximately 2,200 voluntary organisations providing personal social care in Ireland which have evolved over many years in a largely ad hoc, unplanned manner. Some have national coverage and receive substantial public funding; others are very small and local (see Chapter 3.2). The burden of financial and administrative reporting can be very heavy for small organisations and takes scarce staff time away from front line activities. In Chapter 4 we point to a process of consolidation of providers in other EU countries. In our public consultation we raised the question of promoting consolidation in the sector and/or of promoting the use of shared services. The replies indicated clear objections to what was perceived as a 'bigger is always better' bias in the question but some respondents also felt that there were too many similar organisations competing with each other.

The majority of respondents felt that there is a case for amalgamating many of the smaller Section 39 organisations (43 in favour, 32 not in favour, 17 do not know). The main reasons put forward in favour of amalgamations were increased efficiency, effectiveness and value for money, and to reduce duplication of services.

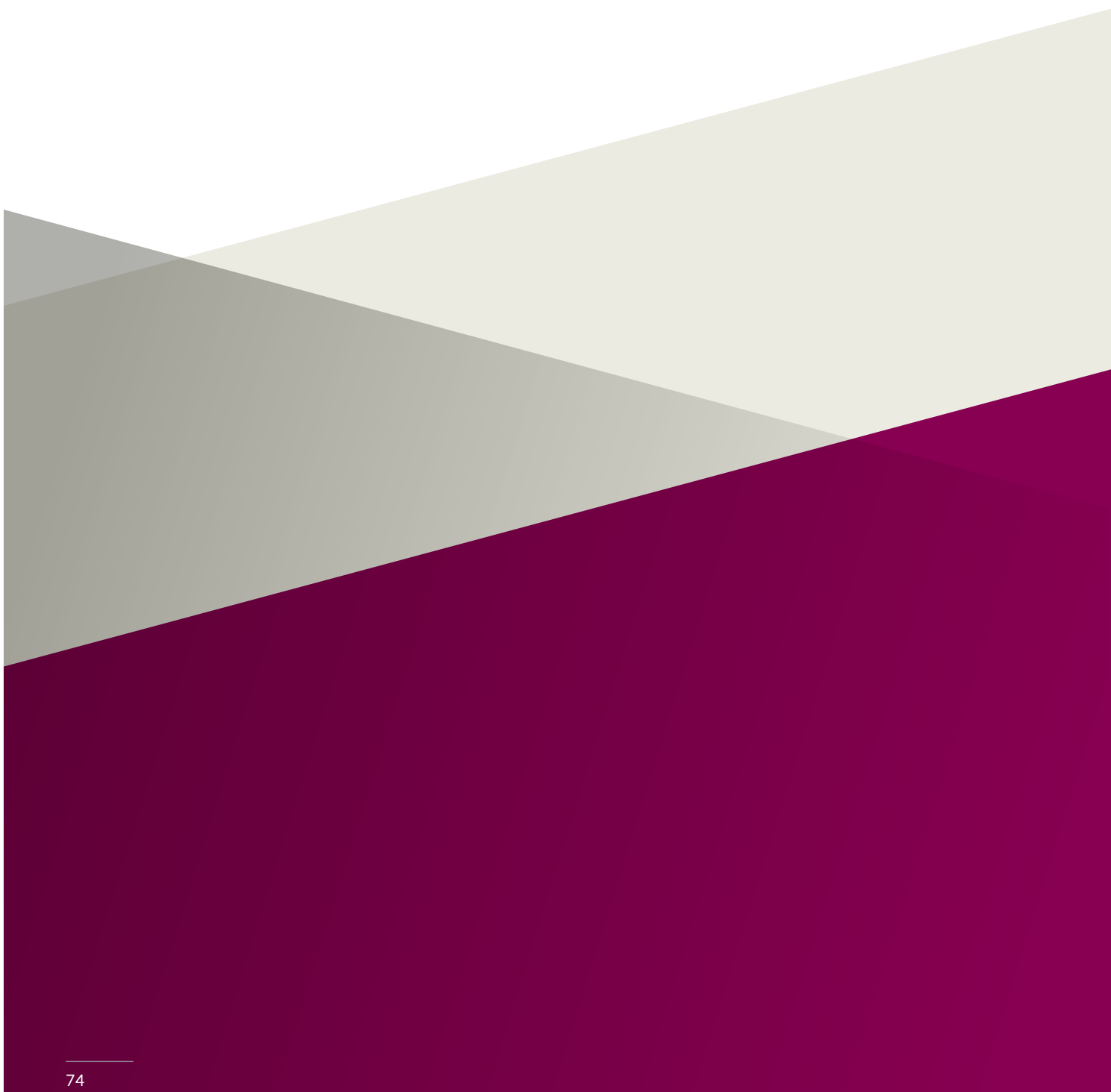
It is clear that the State should not try to prevent local, parent, community or other groups from establishing support groups to help provide personal social care services. However, it must be equally clear that such groups must respect all current legislation and can have no legitimate expectation of automatic public funding. The establishment of a list of essential services to be funded by the State would help to clarify and manage expectations.

As part of stronger recognition of the role of the voluntary sector (see Chapter 8) consideration could be given to the creation of a publicly funded support function to help smaller voluntary organisations meet the costs and expertise requirements of their Service Arrangements and other corporate governance requirements. This could provide shared legal and accounting services, training for Boards and volunteers etc. In Chapter 8 we have recommended lighter control of relatively minor amounts of funding to small organisations. In cases where small organisations express a wish to amalgamate, the process could be supported by the proposed support function.

Recommendation 9.4

Support function

A publicly funded support function should be established to help smaller voluntary organisations. This could provide access to training (for staff and Boards) and shared legal, accounting and other services.



Appendix 1 – List of stakeholder meetings

Acquired Brain Injury Ireland	Mental Health Reform
Alzheimer's Society of Ireland	Mercy University Hospital
Association of Healthcare Chief Executives	Muiriosa Foundation
Beaumont Hospital	National Council for the Blind of Ireland
Brothers of Charity Services Ireland	National Disability Authority
Cappagh National Orthopaedic Hospital	National Federation of Voluntary Bodies
Charities Regulatory Authority	Not for Profit Association
Cheeverstown House	Nursing Homes Ireland
Cheshire Ireland	Our Lady's Hospice & Care Services
Children's Hospital Group	Patient Focus
Comptroller and Auditor General's Office	Rehab Group
Daughters of Charity Disability Support Services	Rotunda Hospital
Department of Health	Saint John of God Community Services
Department of Children & Youth Affairs	Saint John of God Hospital
Disability Federation of Ireland	Saint John of God Hospitaller Services Group
Enable Ireland	St. James's Hospital
Irish Wheelchair Association	St. John's Hospital, Limerick
Health Information & Quality Authority	St. Michael's Hospital, Dun Laoghaire
HSE - Various incl. Leadership Team	St. Vincent's Healthcare Group
Inclusion Ireland	South Infirmary Victoria University Hospital
Ireland East Hospital Group	Stewarts Care Ltd
Irish Catholic Bishops' Conference – Council for Healthcare	Tallaght University Hospital
Marymount University Hospital and Hospice	Temple Street Children's University Hospital
Mater Misericordiae and the Children's University Hospital	The Wheel
Mater Misericordiae University Hospital	Voluntary Healthcare Forum
Mental Health Commission	

Appendix 2 – Ownership of assets

The following table sets out the ownership of assets in voluntary organisations that received more than €20 million in revenue funding in 2017 under Section 38 of the Health Act 2004¹²⁷.

Organisation	Legal structure	HSE revenue funding 2017 (to nearest € million)	Who owns the assets?
Mater Misericordiae Children's University Hospital (MMCUH) holding company	CLG	N/A	MMCUH holding company. It owns the land and buildings of Mater Misericordiae University Hospital and Children's University Hospital (Temple St.), which undertakes the management and administration of the hospitals by way of licence from MMCUH.
Mater Misericordiae University Hospital (MMUH)	DAC	€267m	MMCUH holding company (see above) owns the land and buildings of MMUH, which undertakes the management and administration of the hospitals by way of licence from MMCUH.

127 With the exception of Our Lady's Children's Hospital, Crumlin and Temple Street Children's University Hospital as a single statutory entity will take over the services currently provided by Our Lady's Children's Hospital Crumlin, Temple Street Children's University Hospital and the paediatric services provided at Tallaght University Hospital.

DAC - Designated Activity Company

CLG - Company Limited by Guarantee

LTD - Private Company Limited by Shares

N/A - Not applicable

Provisions on disposal of assets upon winding up	Who decides on disposal of assets in the event of a winding up?
<p>The MMCUH memorandum of association states that in the event of winding up any property shall be transferred to the South Central Province of the Congregation of the Sisters of Mercy, or in the event that it ceases to exist to the Congregation for its charitable purpose, or in the event the Congregation ceases to exist to the Roman Catholic Archbishop of Dublin for his charitable purposes and failing such to a body or bodies of persons having a main object similar to the main objects of MMCUH - to be determined by the members of MMCUH at or before the time of dissolution and in default thereof by the Charities Regulatory Authority. If the above cannot be achieved then to some charitable object which is consistent with the ethos of the Roman Catholic Church.</p>	<p>The Members of MMCUH are the subscribers to the Memorandum of Association and the Provincial Leader of the South Central Province of the Congregation of the Sisters of Mercy in the Republic of Ireland, the Sisters of Mercy Provincial Leadership Team, a nominee of the Roman Catholic Archbishop of Dublin, a representative from the Society of Saint Vincent de Paul, a representative from the Catholic Nursing Guild, one nominee of the respective Medical Boards of the MMUH and the CUH, lay or religious as the Provincial Leader shall from time to time appoint to membership). The Constitution sets out the need for prior approval in writing of the Members or of the Provincial Leader before any alienation of property (including any charge, hire, lease, mortgage, rent, sale etc.)</p>
<p>MMUH's Constitution states that any property shall be given/transferred in the following order:</p> <p>(a) to the Trustees for the time being of the South Central Province (SCP) of the Congregation of the Sisters of Mercy in Ireland for their charitable purposes; or</p> <p>(b) If SCP ceases to exist/does not have charitable status, to the Congregation of Sisters of Mercy for its charitable purpose; or</p> <p>(c) If the Congregation of Sisters of Mercy ceases to exist/ does not have charitable status to the Roman Catholic Archbishop of Dublin for the time being the charitable purposes of the Archdiocese of Dublin; and</p> <p>(d) failing such, to a body or bodies of persons (within the meaning of the Tax Acts) having a main object similar to the main objects of the Company and which shall prohibit the distribution of its or their income and property amongst its or their members to an extent at least as great as is imposed on the Company under the terms of MMUH's constitution; or</p> <p>(e) if effect cannot be given to these provisions the property shall be given or transferred to some charitable object, which is consistent with the ethos of the Catholic Church, with the agreement of the Charities Regulator.</p>	<p>The disposal of assets of MMUH is a matter that must be approved by the MMUH Board in the normal course. Under MMUH's Constitution, approval by its member, MMCUH, in a general meeting is also required if the amount of the disposal exceeds €10m. Under Reg 14.10 of MMUH's Constitution the Board shall not, save in the normal day to day running of the Company, alienate (including sell, charge, lease, mortgage or rent) any property without prior approval of MMCUH.</p>

DAC - Designated Activity Company

CLG - Company Limited by Guarantee

LTD - Private Company Limited by Shares

N/A - Not applicable

Organisation	Legal structure	HSE revenue funding 2017 (to nearest € million)	Who owns the assets?
Cappagh National Orthopaedic Hospital (CNOH)	DAC	€34m	The Lady Martin Trust. Its affairs are looked after by a Trustee Company - The National Hospital Cappagh Trust CLG, whose current Directors are Sisters of Mercy.
St Vincents Healthcare Group (SVHG)	LTD	N/A	The land, property and buildings are owned by the Company - St Vincents Healthcare Group SVHG (legal entity owns the assets)
St. Vincent's University Hospital	See St Vincents Healthcare Group above	€245m	SVHG (see above)
St Michaels Hospital Dun Laoghaire	See St Vincents Healthcare Group above	€25m	SVHG (see above)
Tallaght University Hospital	Charter	€237m	Minister for Health (hospital holds a lease).
Brothers Of Charity (BOC) Services Ireland	CLG	€189m	Assets purchased since incorporation in 2007 are owned by the BOC Services Ireland CLG, unless leased from other parties via lease agreements. Assets pre-2007 owned by BOC Congregation.
Saint John of God (SJOG) Community Services	CLG	€147m	Some assets are owned in whole or in part by SJOG Community Services CLG while others are owned by SJOG Housing Association CLG or leased or licenced from the HSE.
Daughters Of Charity (DOC) Disability Support Services	CLG	€113m	DOC for Persons with a Mental Handicap CLG. This is a Trustee holding company for the properties which is for the beneficial use of the DOC Disability Support Services CLG. The Trustees are the DOC Order.
St. Michael's House	CLG	€84m	Assets are owned by three companies in the St. Michael's House Group: St. Michael's House, St. Michael's House Housing Association and St. Michael's House Properties.

DAC - Designated Activity Company

CLG - Company Limited by Guarantee

LTD - Private Company Limited by Shares

N/A - Not applicable

Provisions on disposal of assets upon winding up	Who decides on disposal of assets in the event of a winding up?
In 2006 the operating assets (excluding land and buildings) and the operating business of the CNOH were transferred by the Trustee from the Lady Martin Cappagh Charity Trust to the CNOH DAC. The Trustee company has issued a licence to the hospital to utilise the land and buildings retained by the Trust for health and educational purposes.	In terms of assets owned by CNOH, the disposal of assets would require: (i) a resolution of the CNOH Board; and (ii) under Reg. 3.4 (d) of CNOH's Constitution if amount involved in the disposal of the asset (or series of related transactions) exceeds €10m a resolution of MMCUH would also be required.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	St Vincent's Healthcare Group
Hospital must acquire consent of the Minister if it wishes to transfer, licence, alter or sub-let any part of the property.	Ministerial consent needed for disposal of property.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	Members of BOC Services Ireland decide which institution to select. Members of BOC Services Ireland are members of the Congregation who are registered as Members in the register of members of the company at the date of adoption of these Articles and such other person as the Regional Leader shall from time to time admit to membership.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	Members of the Company. Current constitution states that the members of the Company shall at all times be the Provincial and the Council of the Province of the Immaculate Conception of the Order for the time being (or its successor in law) and two other Brothers of the Order (Hospitaller Order of SJOG) entitled to attend Provincial Chapters as selected by the Provincial and Council for the time being.
Upon winding up properties owned by DOC for Persons with a Mental Handicap CLG shall be given to the DOC of St Vincent de Paul for its religious, missionary and other solely charitable purposes and failing this to some other charitable institution or institutions having among its principal objects, objects similar to the principal object of the Company. Properties funded by Government Departments/HSE shall revert to original funder.	Members of the Company. Members are the members of the Provincial Council of the DOC of St. Vincent de Paul in Ireland for the time being and such other persons as the Provincial Council shall admit to membership.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	The members of each Company.

DAC - Designated Activity Company

CLG - Company Limited by Guarantee

LTD - Private Company Limited by Shares

N/A - Not applicable

Organisation	Legal structure	HSE revenue funding 2017 (to nearest € million)	Who owns the assets?
Mercy University Hospital Cork (MUH)	CLG	€79m	MUH owns the assets but Mercy Care South (MCS) has reserved powers with regard to their disposal.
Coombe Women and Infants University Hospital	Royal Charter	€61m	Under the Royal Charter 1867 assets are vested in the Board pursuant to the Charter's charitable objectives.
National Maternity Hospital	Royal Charter	€57m	Under the Royal Charter 1903 assets are vested in the Governors (similar to members/shareholders of a company) pursuant to the Charter's charitable objectives.
Rotunda Hospital	Royal Charter	€56m	Assets are vested in the Governors of the hospital.
South Infirmity Victoria University Hospital (SIVUH)	CLG	€54m	Some assets owned by SIVUH. Others leased rent-free from the HSE or the Victoria Trust.
Cope Foundation	CLG	€55m	Cope Foundation CLG.
Muiriosa Foundation	CLG	€53m	The asset base associated with the services delivered by Muiriosa Foundation under its Service Arrangement with HSE spans assets owned by Muiriosa Foundation itself, HSE, Sisters of Charity of Jesus & Mary, and a number of private landlords.
Stewarts Care Limited	LTD	€47m	Stewarts Care Ltd.
National Rehabilitation Hospital	Unincorporated Association	€30m	Owned by a Deed of Trust made between Sisters of Mercy, the National Organisation for Rehabilitation and the Minister of Health.
Our Lady's Hospice & Care Services	DAC	€29m	Our Lady's Hospice & Care Services.

DAC - Designated Activity Company

CLG - Company Limited by Guarantee

LTD - Private Company Limited by Shares

N/A - Not applicable

Provisions on disposal of assets upon winding up	Who decides on disposal of assets in the event of a winding up?
Assets shall be transferred to MCS for its charitable purposes; or in the event that MCS ceases to exist the Southern Province of the Congregation of the Sisters of Mercy; or if it ceases to exist to the Congregation for its charitable purpose; or in the event that the Congregation ceases to exist, to the Roman Catholic Bishop of Cork and Ross for his charitable purposes.	Members of the Company, that is MCS, the Chairperson of the Board of Directors of MCS, the Vice Chairperson of the Board of Directors of MCS; and such other persons as MCS shall appoint.
Charter silent on winding up. However the Board could apply to the Minister for Health to amend the charter under S.76 of Health Act 1970 to provide for its winding up.	The Board.
Charter has perpetual succession, so winding up has never been considered.	The Governors.
Charter silent on winding up. However, assets would need to be used for the "relief of the poor lying-in women of Dublin".	The Governors will have obligations under charity law, trustee law and cy-pres if appropriate to ensure an orderly wind-up and that assets used in accordance with wishes of founder Dr Bartholomew Mosse.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	Members of the Company. 29 members are nominated by the Board of the South Infirmary and 19 by the Board of the Victoria Trust.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	Members of the Company. Members at the time of adoption of the Memorandum of Association and such other people as the Directors admit to membership.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	Members of the Company.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	Members of the Company. Members at the time of adoption of the Memorandum of Association and such other people as the Directors admit to membership.
Deed of trust does not specifically refer to a winding up.	Ongoing discussions about ownership happening between the Sisters of Mercy, HSE and Minister of Health.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	Members of Our Lady's Hospice and Care Services decide which institution to select - the members of Our Lady's Hospice & Care Services Harold's Cross and Blackrock are two Sisters of Charity.

DAC - Designated Activity Company

CLG - Company Limited by Guarantee

LTD - Private Company Limited by Shares

N/A - Not applicable

Organisation	Legal structure	HSE revenue funding 2017 (to nearest € million)	Who owns the assets?
Cheeverstown House	CLG	€25m	Cheeverstown CLG.
Peamount Healthcare	CLG	€25m	Peamount Healthcare.
Royal Eye and Ear Hospital	Royal Charter	€27m	Members of the Executive Council (Board) act as trustees faithful to the original purpose of the Hospital.
Sunbeam House Services	CLG	€24m	Sunbeam House Services.
St. John's Hospital	Unincorporated association	€21m	The assets are vested in the Trustees of the hospital. There shall be not less than three Trustees, who shall be the Catholic Bishop of Limerick and two Sisters of the Little Company of Mary.

DAC - Designated Activity Company

CLG - Company Limited by Guarantee

LTD - Private Company Limited by Shares

N/A - Not applicable

Provisions on disposal of assets upon winding up	Who decides on disposal of assets in the event of a winding up?
The constitution of Cheeverstown CLG which contains a clause on transferring property to a charitable institution or institutions whose objects comply with paragraph (a) of section 24(1) of the Companies Act 1963 (promoting commerce, art, science, religion, charity or any other useful object and not paying dividends to its members).	Members of Cheeverstown CLG.
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	Directors (who are also the Trustees of the charity) decide on disposal.
Executive Council must be faithful to the original Royal Charter and transfer any assets in line with the purpose outlined in the Royal Charter.	Members of the Executive Council (i.e. the Board)
Standard clause on transferring property to a charitable institution or institutions having main objects similar to the main objects of the company, and which prohibits the distribution of income and property among members.	Members of Sunbeam House Services.
There is no provision in the current Scheme of Management for winding up but in such an eventuality the hospital's Trustees would apply to the Charities Regulatory Authority to dispose of the assets cy-pres under the Charities Act.	Charities Regulatory Authority under a cy-pres scheme.

Appendix 3 – Governance arrangements

The following table sets out the governance arrangements in voluntary organisations that received more than €20 million in revenue funding in 2017 under Section 38 of the Health Act 2004¹²⁸.

Organisation	Legal Structure	Registered Charity?	2016 HSE funding - as % of total income [see footnote*]	Who appoints the Board of Directors?	Involvement of a religious congregation? [see footnote**]
Mater Misericordiae University Hospital, Cappagh National Orthopaedic Hospital, and Children's University Hospital (Temple St.) are all wholly owned subsidiaries of Mater Misericordiae and Children's University Hospital (MMCUIH) holding company. For this reason, information on the governance of MMCUIH, which is not itself a Section 38 voluntary organisation, is included here.	CLG	Yes	N/A	Members of MMCUIH in consultation with the Provincial Leader of the South Central Province of the Congregation of the Sisters of Mercy appoint the Board of Governors (equivalent to a Board of Directors), provided that 1 Governor is chosen by the combined Medical Boards of the Mater Misericordiae University Hospital and the Children's University Hospital (Temple St.) and 1 Governor chosen by the combined Nursing Executive of these hospitals.	Yes
Mater Misericordiae University Hospital (MMUH)	DAC	Yes	€246m - 81%	MMCUIH Chair appointed by MMCUIH.	Yes
Cappagh National Orthopaedic Hospital	DAC	Yes	€35m - 86%	MMCUIH Chair appointed by MMCUIH.	Yes

128 With the exception of Our Lady's Children's Hospital, Crumlin and Temple Street Children's University Hospital as a single statutory entity will take over the services currently provided by Our Lady's Children's Hospital Crumlin, Temple Street Children's University Hospital and the paediatric services provided at Tallaght University Hospital.

DAC - Designated Activity Company
CLG - Company Limited by Guarantee
UA - Unincorporated association
N/A - Not applicable

*Percentage is indicative. Non-HSE income can comprise statutorily imposed patient charges, miscellaneous charges, private health insurance income, fundraising etc.
**Involvement solely relates to governance arrangements and not the day-to-day operations of the organisations in question.

How many Directors are nominated / appointed / approved by religious?	Board composition	Criteria for Appointment to the Board	How many meetings per annum?	Board Tenure [A] Chair [B] Other Directors	Notes
All Directors appointed in consultation with the Provincial Leader of the South Central Province of the Congregation of the Sisters of Mercy.	Currently 15 Governors. The Board are to be comprised of not less than 3 who are not related and who are independent of each other.	No set criteria however right balance of requisite skills, knowledge, expertise & experience sought.	4	[A] Determined by the Provincial Leader. [B] 3yrs + 1 further 3yr term (or further terms at the discretion and subject to the invitation of MMCUH Members).	Constitution currently being reviewed. Information included in this row reflects the current situation. The Members of MMCUH are: - the subscribers to the Memorandum of Association and the Provincial Leader of the South Central Province of the Congregation of the Sisters of Mercy in the Republic of Ireland, - the Sisters of Mercy Provincial Leadership Team, - a nominee of the Roman Catholic Archbishop of Dublin, - a representative from the Society of Saint Vincent de Paul, - a representative from the Catholic Nursing Guild, - 1 nominee of the respective Medical Boards of the MMUH and the CUH, - a lay or religious nominee as the Provincial Leader shall from time to time appoint to membership.
All Directors appointed by MMCUH.	Minimum 12 Directors currently 16 (6 ex-officio: the CEO, Director of Nursing, Director of Mission Effectiveness, the Chair of the Medical Board, the Clinical Director and the Director of Finance) plus 7 others. Board must always have a majority of non-executive Directors.	No set criteria however right balance of requisite skills, knowledge, expertise & experience sought.	6 minimum but approx. 8		Constitution currently being reviewed. Information included in this row reflects the current situation. MMCUH is the sole member of MMUH.
All Directors appointed by MMCUH.	Minimum 12 Directors (incl. 6 ex-officio: the CEO, Director of Nursing, Director of Mission Effectiveness, the Chair of the Medical Board, the Clinical Director and the Director of Finance) plus 7 others. Board must always have a majority of non-executive directors.	No set criteria however right balance of requisite skills, knowledge, expertise & experience sought.	6 minimum currently 8		Constitution currently being reviewed. Information included in this row reflects the current situation. MMCUH is the sole member of CNOH.

Organisation	Legal Structure	Registered Charity?	2016 HSE funding - as % of total income [see footnote*]	Who appoints the Board of Directors?	Involvement of a religious congregation? [see footnote**]
St. Vincent's Healthcare Group (Current situation). St Vincents University Hospital and St. Michael's Hospital Dun Laoghaire both form part of St Vincent's Healthcare Group (SVHG). For this reason, information on the current governance of SVHG, which is not itself a Section 38 voluntary organisation, is included here.	DAC	No	N/A	The Board based on recommendations of the Nominations and Remunerations Sub- Committee. At AGM, Board Directors are ratified by the shareholders. Currently the shareholders are the Religious Sisters of Charity but in the future (see row below) it is intended that three or more of the Directors of St. Vincent's Holding CLG will be the shareholders. Chair appointed by the Board.	Yes
St. Vincent's Healthcare Group (proposed future situation)	DAC	No	N/A	St. Vincent's Holdings CLG (which will be a not for profit company regulated by the Charities Regulator), will nominate the Board. Chair to be appointed by the Board.	No
St. Vincent's University Hospital (SVUH)	Branch of SVHG	No, legal entity is SVHG	€231m - 82%	St. Vincents University Hospital is not a company in its own right it is a branch and is overseen by the St. Vincent's Healthcare Group Board (see above)	
St. Michael's Hospital Dun Laoghaire	Branch of SVHG	No, legal entity is SVHG	€25m - 74%	St. Michael's Hospital is not a company in its own right it is a branch and is overseen by the St. Vincent's Hospital Group Board (see above)	
Tallaght University Hospital	Charter	Yes	€205m - 100%	The Minister for Health appoints 8 of the 11 Directors: 4 on the nomination of the Church of Ireland Archbishop of Dublin / President of the Hospital; 2 on the nomination of the Board; 1 on the nomination of Trinity College Dublin; 1 on the nomination of the HSE. The Adelaide Hospital Society appoints 1 Director. The Meath Foundation appoints 1 Director. The National Children's Hospital appoints 1 Director. Chair is appointed by the Board from among those members appointed by the Minister.	Yes

How many Directors are nominated / appointed / approved by religious?	Board composition	Criteria for Appointment to the Board	How many meetings per annum?	Board Tenure [A] Chair [B] Other Directors	Notes
<p>2 Directors nominated by Religious Sisters of Charity. Note: The 2 nominees of the Religious Sisters of Charity resigned from SVHG on 29/5/17 and the Religious Sisters of Charity have not been involved in SVHG since that date. The current constitution of SVHG will be amended accordingly. There is no religious representation on the current Board and nor will there be in the future (see row below).</p>	<p>2-14 Directors (incl. 1 ex-officio: the SVHG Clinical Director) Plus 1 member of the Medical Board and 1 representative from University College Dublin. The Chair may not be selected from among these Directors.</p>	<p>Broad range of skills sought: financial, legal, health and social care, HR, IT, Estate management, leadership, practical governance experience essential (i.e. previous Directorships).</p>	<p>6 minimum</p>	<p>[A] Determined by the Board [B] 3yrs + 2 further 3yr terms</p>	<p>Constitution currently being revised to facilitate the Religious Sisters of Charity transferring their shareholding to a company with charitable status. Information included in this row reflects the current situation.</p>
<p>None. The new constitution of St. Vincent's Holdings (CLG) and revised constitution of SVHG (DAC) will reflect compliance with national and international best practice guidelines on medical ethics and the laws of the Republic of Ireland. St. Vincent's Holdings CLG will not be subject to any religious influence, and will not have any Board members drawn from religious bodies.</p>	<p>Compared to current situation, the SVHG Clinical Director, 1 member of the Medical Board and 1 representative from University College Dublin will be suggested rather than specified Directors.</p> <p>A further difference is that under the proposal to relocate the National Maternity Hospital to the St. Vincent's Elm Park campus, 2 Directors of SVHG will be drawn from the 4 Directors of the National Maternity Hospital at Elm Park who will have been nominated by the NMH Chartered Trust.</p>	<p>Similar to above but will include persons with social-related responsibilities.</p>	<p>Suggested 2-4 meetings per year of the Holding Company as this company will be holding the shares.</p>	<p>[A] Determined by the Board [B] 3yrs + 2 further 3yr terms</p>	<p>Information included in this row reflects the proposed future situation.</p> <p>Our understanding is that SVHG will be a wholly owned subsidiary of St. Vincent's Holdings CLG.</p>
<p>4</p>	<p>11 Directors (Nil ex-officio)</p>	<p>No set criteria however right balance of requisite skills, knowledge, expertise & experience sought by Nominations Sub-Committee.</p>	<p>6 minimum but approx. 8-10</p>	<p>[A] 3yrs + 2 further 3yr terms [B] 3yrs + 2 further 3yr terms</p>	<p>Charter currently being amended ahead of new National Children's Hospital. Information included here reflects the current situation.</p> <p>Tallaght University Hospital is a result of the amalgamation of three Dublin city centre hospitals namely the Adelaide Hospital, the Meath Hospital and the National Children's Hospital. The Adelaide Hospital Society, Meath Foundation, and the National Children's Hospital are now charities which support Tallaght University Hospital.</p>

Organisation	Legal Structure	Registered Charity?	2016 HSE funding - as % of total income [see footnote*]	Who appoints the Board of Directors?	Involvement of a religious congregation? [see footnote**]
Brothers Of Charity Services Ireland (BOCSI)	CLG	Yes	€185m - 93%	The Board based on recommendations of the Nominations Sub-Committee, subject to approval of the Regional Leader of the Congregation of BOCSI. Chair appointed by the Board based on recommendations of the Nominations Sub-Committee and subject to approval by the Regional Leader of the Congregation of BOCSI.	Yes
Saint John of God Community Services	CLG	Yes	€139m - 87%	The Board nominates and appoints its Directors. They are then approved by the Provincial of the Hospitaller Order of Saint John of God at the AGM. Chair appointed by the Board.	Yes
Daughters Of Charity Disability Support Services	CLG	Yes	€106m - 91%	Daughters of Charity appoint 3 members of the Daughters of Charity and the Board based on the recommendations of the Nominations Sub-Committee appoints the 7 others. Chair is appointed by the Daughters of Charity.	Yes
St. Michael's House	CLG	Yes	€78m - 90%	The Board based on nominations of the Governance Committee. In 2017 and 2018 the Board placed an open call for Directors in the national media. Chair appointed by the Board.	No
Mercy University Hospital Cork (MUH) is a wholly owned subsidiary of Mercy Care South holding company. For this reason, information on the governance of Mercy Care South, which is not itself a Section 38 voluntary organisation, is included here.	CLG	Yes	N/A	All Board appointments at the invitation of and subject to approval of Mercy Care South PJP. Mercy Care South CLG has the same members as Mercy Care South PJP, which is public juridic person established under Canon Law. Chair appointed by the Board.	Yes

How many Directors are nominated / appointed / approved by religious?	Board composition	Criteria for Appointment to the Board	How many meetings per annum?	Board Tenure [A] Chair [B] Other Directors	Notes
All Directors	7-16 Directors (Nil ex-officio)	No set criteria but regional representation from BOCSI, gender balance, and skill mix sought.	4 minimum	[A] 3yr term (max 9 yrs) [B] 3yr + 2 further 3yr terms	Members of BOCSI are members of the Congregation who are registered as Members in the register of members of the company at the date of adoption of these Articles and such other person as the Regional Leader shall from time to time admit to membership.
All. Members of the company (Brothers of the Hospitaller Order of Saint John of God) approve the recommendations and all Directors are approved by the Provincial Leader of the Hospitaller Order of Saint John of God.	7-11 Directors (Nil ex-officio)	Competency framework	10	[A] 3yrs + further 2 3yr terms [B] 3yrs + further 2 3yr terms	Members of the Company shall at all times be the Provincial and the Council of the Province of the Immaculate Conception of the Order for the time being (or its successor in law) and two other Brothers of the Order (Hospitaller Order of SJOG) entitled to attend Provincial Chapters as selected by the Provincial and Council for the time being. Services of the Hospitaller Order of Saint John of God are grouped into a number of companies including Saint John of God Community Services CLG, Saint John of God Hospital CLG, Saint John of God Housing Association CLG. Information here relates to Saint John of God Community Services CLG which is a Section 38 voluntary organisation.
3 Directors	3-15 Directors (currently 10) (Nil ex-officio)	No set criteria but broad range of skills sought: financial, legal, medical, experience in public bodies, family member. 3 minimum but approx. 10	3 minimum but approx. 10	[A] No set limit but endeavour to rotate every 6yrs [B] No set limit but endeavour to rotate every 6yrs	The members of the company are members of the Provincial Council of the Daughters of Charity of St. Vincent de Paul in Ireland and other persons admitted by the Provincial Council.
None	5-13 Directors (Nil ex-officio) At least 2 Directors with direct experience of people who live with intellectual disabilities.	Competency Framework. Broad range of skills sought: financial, strategic, general management, estate management, delivery of health or social care services.	9	[A] Determined by the Board [B] 3yrs + 1 further 3yr term	
Directors of Mercy Care South must be members of the PJP, have been invited to become a Director by the PJP, and have their proposed appointment approved in writing by the PJP. The 'Canonical Statutes and By-Laws' of Mercy Care South PJP set out that all members must be committed Catholics within the Catholic community. Currently 5 of its 12 Directors are religious.	12 Directors (Nil ex-officio)	Commitment to ethos and mission. Skills sought: governance, legal, finance, general management, HR, Medical.	4	[A] Determined by the Board [B] 3yrs + 2 further 3yr terms	Current composition will change over next 2 years from 7 Lay and 5 Religious to 9 Lay and 3 Religious. Sisters of Mercy nominate 2 Directors. Bishop of Cork and Ross nominates 1 Director.

Organisation	Legal Structure	Registered Charity?	2016 HSE funding - as % of total income [see footnote*]	Who appoints the Board of Directors?	Involvement of a religious congregation? [see footnote**]
Mercy University Hospital Cork (MUH)	CLG	Yes	€78m - 76%	Mercy Care South on the recommendation of MUH Nominations Committee. Chair appointed by Mercy Care South.	Yes
Coombe Women and Infants University Hospital	Royal Charter	Yes	€54m - 76%	The Board based on recommendations of the Nominations Sub-Committee. Chair is Lord Mayor of Dublin (ex-officio). A de-facto Chair is also appointed by the Board.	No
National Maternity Hospital	Royal Charter	Yes	€51m - 75%	The Governors of the Hospital (equivalent to members of a company) appoint the Executive Committee (equivalent to a Board of Directors), based on the recommendations of a Nominations Committee. Chair is Archbishop of Dublin (ex-officio) who generally does not attend or take the Chair if he does. Vice Chair is Lord Mayor of Dublin (ex-officio). A Deputy Chair (de-facto Chair) is elected at each AGM.	Yes
Rotunda Hospital	Royal Charter	Yes	€52m - 100%	The Board of Governors (equivalent to a Board of Directors) on the recommendation of Governance Audit Committee. Chair appointed by the Board. Nominations for Chair are requested and assessed on the recommendation of a sub-committee established and led by the outgoing Chair to select the successor.	Yes
South Infirmary Victoria University Hospital (SIVUH)	CLG	Yes	€53m - 73%	Members of the company elect up to 8 Up to 4 Directors are from members of the Company nominated by the South Infirmary and up to 4 Directors from members of the Company nominated by the Victoria Trust. These elected Directors may co-opt up to 4 additional advisory Directors who need not be members of the Company. Chair appointed by the Board.	Yes
Cope Foundation	CLG	Yes	€53m - 91%	Members of Cope Foundation elect the Board. Chair appointed by the Board.	Yes

How many Directors are nominated / appointed / approved by religious?	Board composition	Criteria for Appointment to the Board	How many meetings per annum?	Board Tenure [A] Chair [B] Other Directors	Notes
All Directors appointed by Mercy Care South.	3-12 Directors (Nil ex-officio) There are no religious on the Board of MUH.	Competency framework. Skills sought: Governance, legal, finance, general management, HR, IT, Health Sector.	11 minimum	[A] 3yrs + 1 further 3yr term [B] 3yrs + 2 further 3yr terms	
None	8-21 Directors (currently 11) (incl. 2 ex-officio: Lord Mayor of Dublin as Chairperson, Master/CEO).	Use Institute of Directors 'Skills Matrix Sample'	6 minimum but approx. 7 plus	[A] ex-officio. Elected Chair 3yrs + 1 further 3yr term [B] 3yrs + 2 further 3yr terms	
None, apart from ex-officio members.	No Minimum - 31 aximum (incl. 6 ex-officio: Archbishop of Dublin, Lord Mayor of Dublin, Administrator of St Andrews Parish, The Master, Honorary Secretary, Honorary Treasurer), 2 nominated by Minister for Health, 2 nominated by Dublin City Council, plus 21 ordinary members - of which 6 must be women.	Nominations Committee looks at the particular skill sets within the existing board and identifies any specific needs.	12	[A] ex-officio. Deputy Chair is elected for a 1yr term, renewable without limits. [B] No limits on tenure	Board tenure rules under revision. The Governors are equivalent to members or shareholders of a Company, there is a maximum limit of 100 Governors. Governors are elected by the Executive Committee.
None, apart from ex-officio members.	60 maximum (currently 25) (incl. 5 ex-officio: Lord Mayor of Dublin, Archbishop of Armagh, Archbishop of Dublin, Dean of St Patrick's, Archdeacon of Dublin). Governors that are registered practicing medical doctors not to exceed the non-medical governors.	Governance Audit Committee determines skill-sets required incl.legal, HR, procurement, financial (inc. audit), property management, risk management, medical/midwifery/ nursing, patient/ consumer interest, strategic planning, ICT knowledge, academic component/ research/ teaching.	4 minimum but approx. 10	[A] 3yrs + 1 further 2yr term [B] 3yrs + 2 further 3yr terms	
None	3-12 Directors (Nil ex-officio)	For elected Directors: minimum 2 years serving on Committee of Management of the South Infirmary or Victoria Trust. For Advisory Directors: whatever skill-set is required by the Board at time of appointment.	10	[A] 1yr term up to a maximum of 6 consecutive yrs [B] 1yr term up to a maximum of 9 consecutive yrs	The South Infirmary Victoria University Hospital is a result of the amalgamation of the South Charitable Infirmary (Roman Catholic ethos) and the Victoria Hospital (Protestant ethos). These are now charities which support SIVUH. The South Infirmary has the right to nominate up to 60% of SIVUH members and the Victoria Trust 40%. The Victoria Trust is operated by the Church of Ireland.
None	6-12 Directors (Nil ex-officio)	Strategy and Nomination Committee puts forward recommendations based on collective Board balance of skills/competencies.	12	[A] 3yrs + 1 further 3yr term [B] 3yrs + 2 further 3yr terms	Members of the company are the members at the time of adoption of the Memorandum of Association and such other people as the Directors admit to membership.

APPENDIX 3 - GOVERNANCE ARRANGEMENTS

Organisation	Legal Structure	Registered Charity?	2016 HSE funding - as % of total income [see footnote*]	Who appoints the Board of Directors?	Involvement of a religious congregation? [see footnote**]
Muiriosa Foundation	CLG	Yes	€49m - 94%	The Board of Directors. Chair is appointed by the Board.	Yes
Stewarts Care Limited	LTD	Yes	€44m - 81%	The persons comprising the Board of Stewarts Foundation CLG (and no other persons) shall comprise the Board of Stewarts Care Limited. The members of Stewarts Foundation CLG elect the Board of Stewarts Foundation CLG. Chair appointed by the Board.	No
National Rehabilitation Hospital	UA	Yes	€28m - 82%	The Provincial Leader of the South Central Province of the Sisters of Mercy. Chair appointed by the Provincial Leader of the South Central Province of the Sisters of Mercy.	Yes
Our Lady's Hospice & Care Services	DAC	Yes	€28m - 65%	The Board, based on recommendations from Nominations Committee. Chair appointed by Board.	Yes
Cheeverstown House	CLG	No	€24m - 89%	Members of the company. Every Member of the company is approved by 'Cheeverstown CLG'. Chair appointed by the Board.	No
Peamount Healthcare	CLG	No	€25m - 80%	Members of the company, based on recommendations of the Nominations Sub-Committee. Chair appointed by the Board.	No

How many Directors are nominated / appointed / approved by religious?	Board composition	Criteria for Appointment to the Board	How many meetings per annum?	Board Tenure [A] Chair [B] Other Directors	Notes
None	5-13 Directors (Nil ex-officio)	No set criteria but Nominations Committee identifies selection criteria at time of Board member selection, with an overarching requirement being the capacity of a potential Board member to contribute to the organisation's core purpose.	5 minimum	[A] Determined by the Board [B] 3yrs + 2 further 3 yr terms	Members of the company are the current Directors of the company. Muiriosa Foundation incorporated in 2012, prior to that it was Sisters of Charity of Jesus & Mary Services.
None	6-12 Directors (incl. 3 ex-officio: Chair, Vice-Chair, Honorary Secretary)	At the discretion of Board on the recommendation of Nominations & Remuneration Sub-Committee, which is composed of the Chairman, Vice-Chairman, Honorary Secretary and Chief Executive.	9	[A] 3yrs + 1 further 3yr term [B] 5yrs + 2 further 5yr terms	
All Directors	7-16 Directors (incl. 2 ex-officio: Director of Nursing & Chair of Medical Board). Plus a member of staff (other than the medical staff) and, where possible, users or former users of medical rehabilitation services.	No set criteria but Board endeavours to reflect diversity in terms of gender, skill set and areas of competency.	11	[A] 3yrs, renewable [B] 3yrs, renewable	
2 Directors are nominees of the Religious Sisters of Charity.	2-13 Directors (Nil ex-officio)	Nominations Committee skills matrix, and service on a Board Sub-Committee before appointment to the Board.	6	[A] Determined by the Board [B] 6 years unless the Congregational Leader invites the Director to serve an additional period in office.	Members of Our Lady's Hospice & Care Services Harold's Cross and Blackrock are two Sisters of Charity.
None	3-15 Directors (Nil ex-officio)	Competency framework. Board members on basis of business experience or are retired senior public officials or are health professionals.	9	[A] No limits on tenure [B] 2 longest-serving Board members retire from office each year but are eligible for re-election. No limits on tenure.	Constitution currently being revised. Information included here reflects the current situation.
None	7-12 Directors (Nil ex-officio)	Competency framework	6 minimum	[A] 3yrs + 1 further 3yr term [B] 3yrs + 2 further 3yr terms	Members of the company are the subscribers to the Memorandum of Association, each of the Directors of the Company and such other persons and bodies who apply for membership and agree to adopt and promote the principles and main objects of the company and who are accepted and admitted as members by the Directors.

Organisation	Legal Structure	Registered Charity?	2016 HSE funding - as % of total income [see footnote*]	Who appoints the Board of Directors?	Involvement of a religious congregation? [see footnote**]
Royal Victoria Eye & Ear	Royal Charter	Yes	€25m - 88%	The Members of the company elect the Executive Council (equivalent to a Board of Directors), based on recommendations of a Nominations Sub-Committee. Chair (President) appointed by the Members.	No
Sunbeam House Services	CLG	Yes	€25m - 96%	Sunbeam House Trust currently entitled to appoint 3 Directors. The other members of the Board appoint 5 Directors and a Managing Director. (Note: these provisions are currently under review). Chair appointed by the Board.	No
St. John's Hospital (current situation)	UA	Yes	€18m - 72%	The Board of Governors appoints the Committee of Management (equivalent to a Board of Directors) subject to specified criteria set out under 'Board composition'. Chairman of the Board of Governors is the Catholic Bishop of Limerick.	Yes
St. John's Hospital (proposed future situation)	UA	Yes	N/A	The Trustees based on recommendations of the Board. Chairman of the Board of Governors will continue to be the Catholic Bishop of Limerick.	Yes

DAC - Designated Activity Company
 CLG - Company Limited by Guarantee
 UA - Unincorporated association
 N/A - Not applicable

*Percentage is indicative. Non-HSE income can comprise statutorily imposed patient charges, miscellaneous charges, private health insurance income, fundraising etc.

**Involvement solely relates to governance arrangements and not the day-to-day operations of the organisations in question.

How many Directors are nominated / appointed / approved by religious?	Board composition	Criteria for Appointment to the Board	How many meetings per annum?	Board Tenure [A] Chair [B] Other Directors	Notes
None	20 members (incl. 3 ex Officio members: Lord Mayor of Dublin, a Dublin City Council nominee and the President of the Hospital Council) plus 3 medical staff and 14 additional members.	Competency framework	9	[A] Determined by the Executive Council [B] 3ys + 2 further 3yr terms	
None	9 Directors (Nil ex-officio)	Skills sought as identified by the Board	No minimum but approx. 10 to 12	[A] 1yr + 2 further 1yr terms [B] No limits on tenure	Board tenure rules under revision.
2 Directors are Sisters of the Little Company of Mary being Governors nominated by the Sister Superior of the Little Company of Mary, plus ex-officio members.	ex-officio members: Catholic Bishop of Limerick, the Mayor of Limerick, the Administrator of St. John's Parish. Plus 2 Sisters of the Little Company of Mary being Governors nominated by the Sister Superior of the Little Company of Mary and 3 Governors (1 current or former member of the Medical Staff nominated by the Medical Board; 1 current or former member of the medical staff elected by the Board of Governors; and 1 lay person elected by the Board of Governors).	No set criteria	11	[A] N/A [B] The Committee of management is constituted annually by the Board of Governors	The Board of Governors consists of Annual Governors on payment of a yearly sum of £25, Life Governors on payment of £100, plus the following ex-officio members: Catholic Bishop of Limerick, The Reverend Administrator of the Parish of St. John, the Parish Priests of the Parishes of St. Munchin, St. Mary, St. Patrick and St. Michael, two members of the Little Company of Mary nominated by the Sister Superior, the Mayor of Limerick and four members of the Limerick Corporation nominated by the Corporation. Constitution currently being revised. Information included in this row reflects the current situation.
2 ex-officio members.	9-12 Directors (incl. 6 ex-officio members: Catholic Bishop of Limerick, the Reverend Administrator of the Parish of St. John's, the Mayor of the Metropolitan District of Limerick, the Chairperson of the Medical Board or other such clinical governance committee member, the Secretary of the Medical Board or other such clinical governance committee, a public representative as nominated by Limerick City and County Council) plus 4-6 persons who have been identified as suitable by the Nominations and Governance Committee and recommended by the Board and appointed by the Trustees.	Appropriate and required levels of skills, competence and experience in the following areas: Sectoral, nursing, professional and relevant technical competencies; legal, corporate governance, audit; financial management, risk management; business / managerial, administrative type competencies; and strategic planning / innovation, change management.	11	[A] N/A [B] 3yrs + 2 further 3yr terms	Constitution currently being revised. Information included in this row reflects the proposed future situation.

Appendix 4 – List of abbreviations

ABF	Activity Based Funding
CEO	Chief Executive Officer
CHO	Community Healthcare Organisation
CMSU	Contract Management Support Units
COI	Church of Ireland
CRO	Companies Registration Office
CSO	Central Statistics Office
EU	European Union
FOI	Freedom of Information
HIQA	Health Information and Quality Authority
HIPE	Hospital In-patient Enquiry
HRB	Health Research Board
HSE	Health Service Executive
ICT	Information Communication Technology
IRG	Independent Review Group
MOU	Memorandum of Understanding
NDP	National Development Plan
NHS	National Health Service (UK)
ODCE	Office of the Director of Corporate Enforcement
PJP	Public Juridic Person
SA	Service Arrangement
UN	United Nations
CLG	Company Limited by Guarantee
DAC	Designated Activity Company
LTD	Private Company Limited by Shares
UA	Unincorporated Association

Supporting documentation

The following supporting documentation is available on the Department of Health website:

1. Consultation questionnaire on the role of voluntary organisations in publicly funded health and personal social services
2. Easy read guide to the consultation on the role of voluntary organisations in publicly funded health and personal social services
3. Report of the public consultation on the role of voluntary organisations in publicly funded health and personal social services
4. Joan Quigley and Jean Long, Health Research Board, '*Governance of voluntary health and social care providers – England and Canada*', 2018

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