The curse of the Irish Hospitals' Sweepstake: A hospital system, not a health system

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Abstract:

Why did the Irish health service develop in the way that it did? How did small, local hospitals become so important? And was the policy focus misplaced on hospitals rather than on people's health? In this paper Mary E. Daly argues that the Irish health service has been shaped by historical forces, some of which are now largely forgotten, even though their legacy is evident in today's health service and in current policy debates. These forces include the Irish hospital sweepstake, Catholic social teaching and the principle of subsidiarity, and political patronage. Ultimately, this paper argues that an understanding of these historical forces can assist policy-makers. In other words, history matters.[1]

A brief snapshot of aspects of the Irish health system which had emerged by 1970 reveals some fascinating facts. By the mid-1960s Ireland had over 20,000 acute-care hospital beds; that represented 7.2 beds per 1,000 of population, a figure exceeded only by Sweden and Luxembourg, and substantially higher than England and Wales, at 4.3 per 1000, Northern Ireland 5.5, or the United States 4.9.[2] Minister for Health Erskine Childers reminded the inaugural meeting of the National Health Council in February 1971 that 'we have the highest proportion of hospital beds to population in Western Europe'.[3] To fill these beds, the rate of hospital admissions was growing. In 1964 the rate of hospital admissions in Ireland was 100 per 1,000 of the population; in 1951 that figure had been 60 per 1,000. Despite the high rate of hospital admissions, Irish patients spent more days in hospital – an average of 20 days in 1960 (the figures exclude long-stay institutions) and fewer patients were treated annually per hospital bed: 16 patients

[1] My analysis concentrates on hospitals, more specifically on general/acute hospitals; it does not deal with long-term institutional care for mentally handicapped, mentally-ill, or geriatric patients.
[2] *Outline of the future hospital system. Report of the Consultative Council on the general hospital services* (Dublin, 1968), (hereafter referenced as the Fitzgerald Report), p. 49.
[3] *First report national health council*, 31 March 1971, p. 8.

per bed, compared with 19 in Sweden, 22 in England and Wales and 30 in the USA.[4] All of this suggests that there were too many hospital beds.[5]

Detailed statistics indicate the leisurely pace of hospital treatment; the average patient admitted to the National Maternity Hospital in Holles Street, stayed for 8.9 days, while in Waterford Maternity hospital the average was 12.9 days. Medical patients admitted to the county hospital in Wexford stayed for an average of 23.3 days; those in Castlebar for only 9.6 days. The explanation for these wide variations may lie in occupancy rates: Castlebar had an occupancy rate of 90 per cent,- which was comparable to the Dublin voluntary hospitals, whereas in Wexford the occupancy rate was under 70 per cent.[6] A study of in-hospital treatment for a variety of standard diseases and procedures carried out in the early 1970s showed a very wide variety in the length of stay between different Irish hospitals – the variation was much wider than in Scotland, and Irish patients generally spent longer periods in hospital than their Scottish counterparts. In a comment on this report, the Medico-Social Research Council concluded that 'Patients increase to fill the available hospital beds'.[7]

The other noteworthy characteristic of Irish hospitals at this time is that they tended to be small. A report published in 1970 described the Irish hospital system as 'one of a large number of small institutions scattered throughout the country'. This description was an understatement: at the time a total of 169 hospitals provided acute medical, surgical and maternity services. Only three hospitals – all in Dublin – had more than 300 beds.

So let's focus on the critical questions:

- Why such a high ratio of hospital beds per 1,000 of population?
- Why such long stays?
- Why so many hospitals?

[4] Fitzgerald Report, pp. 49-50. Figures relate to short-term patients, not those with chronic conditions requiring long-term hospitalisation.
[5] Department of Health, *The Health Services and their future redevelopment* (Dublin 1966), pp. 40-41.
[6] Fitzgerald report, Appendix, pp. 132-135.
[7] *Report of the Medico-Social Research Council*, 1972.

To begin we must recognise that the twentieth-century century saw a significant international expansion of hospital medicine. Christopher Lawrence has described the hospitals of the inter-war years as 'Cathedrals of Medicine'.[8] 'In Britain the number of beds per thousand of population doubled 1860 to 1940, and had doubled again by 1980.' Greater resort to surgery for a range of illnesses, medicalisation of child-birth, increased use of X-rays, blood tests, blood transfusions, pathology, microbiology and other diagnostic services; increased specialisation in medical expertise, and the locating of that specialist expertise in hospitals, plus the Listerian/antiseptic revolution, which meant that hospitals were no longer feared as a source of disease, brought treatments and patients into the hospital environment.[9] These factors were common throughout the developed world, and in Ireland the development of specialist treatments and diagnostic services lagged behind countries such as the USA. And yet Ireland had an exceptionally high number of hospital beds, a high rate of admissions and long-stays in hospital.

I argue that the medical market place in Ireland pushed medical care and patients towards hospitals to a greater extent in Ireland than in the UK or other developed countries for two reasons: firstly, the Irish Hospitals' Sweepstake provided a substantial amount of money that was available to fund the construction of hospital beds and to subsidise the running costs of voluntary hospitals; money that was not available to support out-patient or general practice services.

The second important factor is the influence of Catholic social teaching and the principal of subsidiarity. Catholic social teaching regarded the family as the primary provider of income and care, including medical care; the state should not assume responsibility for matters that are properly the remit of the family, they should only step in when the family failed in its role. Providing health-care for the poor – via the dispensary system – was acceptable when the poor could not provide for themselves. By the mid-twentieth century, given the high cost of hospital treatment, Catholic social teaching conceded that families could find the cost of hospital treatment beyond their means, and that

[8] Christopher Lawrence, 'Continuity in crisis: medicine, 1914-1945', in W.F. Bynum, Anne Hardy et al. *The western medical tradition, 1800 to 2000*, (Cambridge, 2006), p. 269.
[9] Roy Porter, 'Hospitals and surgery', in Roy Porter (ed.), *The Cambridge history of medicine*, (Cambridge, 2006), p 209.

consequently the state should subsidise this cost for all but the wealthiest of the population, whereas most families were expected to bear the full cost of attending a GP and prescription medicines.

The critical period when Irish healthcare was transformed by these forces is the period from the end of the Second World War to the mid/late 1960s. Many European countries introduced comprehensive healthcare for their citizens during these years, continuing a process that had begun in the 1930s.[10] While Ireland did not introduce a national health system the range of free or subsidised health schemes was significantly extended. This important fact has tended to be obscured and even forgotten, because of the attention given to the failed Mother and Child Scheme.[11] Although the 1953 Health Act has attracted much less attention, it represented a major expansion in government support for healthcare. The Act, introduced by a Fianna Fáil government, extended free or heavily-subsidised hospital treatment to approximately 85 per cent of the population; it also implemented a scaled-down Mother and Child scheme, which provided free care for expectant mothers and newborn infants up to six weeks of age, though high-income families were required to pay a nominal charge.[12] The 1953 Act also modified the traditional dispensary system, abolishing the degrading 'red ticket' – a legacy of the nineteenth century poor law – which meant that a patient had to apply to a poor law guardian (later a member of the local authority) for a ticket every time they wanted to attend a dispensary free of charge. In its place local authorities drew up a list of those eligible for free treatment – i.e. medical cards – and this list was revised annually, but there was no extension of eligibility.

Entitlement to free dispensary treatment continued to cover approximately 30 per cent of the population, which was approximately the proportion eligible in the 1920s. A medical card entitled the holder to free medicine, appliances and other needs such as bandages, and in larger cities there was a dispensing pharmacy in the dispensary building. However, most dispensary doctors had to supply drugs directly to their

[10] Dorothy Porter, *Health, civilization and the state. A history of public health from ancient to modern times,*(London, 1999), pp. 209-218.
[11] For details of the Mother and Child scheme, see Ruth Barrington, *Health medicine and politics in Ireland, 1900-1970* (Dublin, 1987), pp 195-222.
[12] Barrington, *Health medicine and politics in Ireland*, pp. 222-250.

patients; they bought stocks through the Department of Local Government combined purchasing scheme. Medical card holders were also entitled to free hospital treatment.[13] There were no income/farm size criteria to determine entitlement to a medical card, and some local authorities were more generous than others in granting medical cards. In 1965 29.2 per cent of the national population had a medical card; the counties with the highest percentage of population holding medical cards were Carlow (47%) Longford (46%); Roscommon (45%); Kilkenny (44%) and Monaghan (42%); in Dublin city and county only 16 and 13 per cent of the population had medical cards.[14]

The most significant aspect of the 1953 Act was the provision of free or heavily-subsidised hospital treatment for the overwhelming majority of the population. Those eligible included all who paid social insurance, all medical card holders, and those with an income level or farm valuation below specified thresholds. By the mid-1950s approximately 85 per cent of the population was entitled to free or state-subsidised hospital treatment; the level of subsidy and the charges imposed on patients changed from budget to budget.[15] By 1966 90 per cent of the population were entitled to subsidised hospital care.[16] In 1966 the 55-60 per cent middle-income group – i.e. those who did not have a medical card – were charged a maximum of 10/- a day (approximately 70 cent) for hospital treatment and maintenance. In practice this was very much a maximum figure: the 1966 White Paper estimated that in the previous year 60 per cent of the middle-income group were charged nothing for a hospital stay, and only half of the remaining 40 per cent were charged more than 5/- a day (approx. 35 cent).[17] At the time the average cost of a week in a county hospital (it would be dearer in the more specialist voluntary hospitals) was £23[18] so the maximum charge amounted to approximately 10 per cent of the total cost, and the average sum paid was half that amount. Non-payment among those billed was rife.

Voluntary Health Insurance, introduced by the Second Inter-Party Government in 1955, was designed to cover hospital treatment for the wealthiest 15 per cent of the

[13] *The Health Services and their future redevelopment,* pp. 29-30
[14] *The Health Services and their future redevelopment*, pp. 27-28
[15] Barrington, *Health medicine and politics in Ireland*, p. 253.
[16] *The Health Services and their future redevelopment,* pp. 11-12.
[17] *The Health Services and their future redevelopment*, pp. 37-8.
[18] Fitzgerald Report, Appendix A, hospital statistics, 1966.

population – those not eligible for free or subsidised treatment under the 1953 Act. By 1957 there were 25,000 subscribers; by 1966 the number had risen to 250,000. It reached 300,000 by 1968 and 500,000 by 1972.[19] VHI also limited its cover to hospital treatments and diagnostics, and only in-patient, not out-patient treatments (there appears to have been something of a grey area regarding health insurance and out-patient hospital procedures, i.e. x-rays). This limited coverage again reflected core principles in Irish health care that appear to have been common to both Fianna Fáil and Fine Gael until at least the mid-1960s.[20] The 1966 White Paper restated these principles very clearly:

> In developing the services on the lines summarised above, the Government did not accept the proposition that the State had a duty to provide unconditionally all medical, dental and other health services free of cost for everyone, without regard to individual need or circumstances . . . . Thus, general medical services (GP) have remained available only to about thirty per cent of the population, because it is considered that the expenses arising from attending a general practitioner are not normally an undue strain on families in the middle income group. On the other hand, eligibility for hospital and specialist services, which are likely to be much more costly, has been extended to a far wider group of the population, and, in general, those outside the groups statutorily entitled to the services can use them if they can show hardship.[21]

To summarise, during the 1950s free or heavily-subsidised hospital treatment was provided for the overwhelming majority of the population. By contrast, entitlement to free GP or community care was provided for approximately 30 per cent of the population – roughly the same proportion as in 1920; the only significant change was the replacement of the 'red ticket' with a medical card. The range of services and treatments provided through the dispensary system did not evolve in line with developments in medicine. In 1961, Dr. T. F. O'Higgins, Fine Gael spokesman on health and former Minister for Health, claimed that the average annual cost of medicine for patients treated by dispensary doctors amounted to only 4/ - to 6/- (30 cent- 40 cent) per capita. Many dispensary doctors were seriously overworked, caring for up to 2,000 patients. There was minimal provision for home nursing for dispensary patients, with only 171 public health nurses, compared with 674 dispensary doctors. The nurse's time

[19] *The Health Services and their future redevelopment,* p. 40*;* David Mitchell, *A 'peculiar'place. The Adelaide Hospital, Dublin. Its times, places and personalities 1839-1989*, (Dublin, no date given), p. 207.
[20] The 'Just Society', a Fine Gael policy document issued in 1965, proposed major changes in state provision for health services.
[21] *The Health Services and their future redevelopment*, p. 16.

had to be divided between public health functions – school health examinations, immunisation, the Mother and Child service – ante-natal and neo-natal care, and more general nursing care for the dispensary patients.[22] So it is not surprising that 'The dispensary doctor in most cases acts merely as a conduit pipe from the home to the hospital' – where patients would get free nursing care, free medicine, dressings, diagnostic services, plus meals, heated accommodation running water and baths – facilities that were often lacking in their homes. Thus, the structure and financial basis of the dispensary service encouraged a high level of hospital admissions.[23]

Those who did not qualify for free visits to the dispensary doctor but found the cost of visiting a GP rather onerous also had a strong incentive to try and gain admission to hospital, even for basic diagnosis or nursing care – hence the practice of visiting hospital casualty units for minor treatments. By the 1960s the notional 10/- a day for being in hospital, with food, heat, medicine, x-rays and quality nursing care provided, was less than the cost of a GP visit – 15/- [24] (approx 1 Euro) – and as we have seen the hospital charge was often waived or reduced. The daily hospital charge did not increase during the 1960s – at a time when most wage and salary earners enjoyed regular pay increases and spiralling inflation meant that most other charges were rising. Families not eligible for dispensary treatment were theoretically required to pay for out-patient visits to specialists and for diagnostic services, 2/6 to see a specialist (one-sixth the cost of a GP visit) and 7/6 for an x-ray; however it appears that many either failed to pay or had charges waived, the amount collected was relatively small, only £48,000 nationwide in 1965.[25] Nevertheless, it was cheaper to by-pass out-patient services in favour of hospital admission, where all these services were free, and this was also true for VHI patients, because their insurance covered in-patient, but not out-patient treatment.

It is no great surprise therefore that by the 1960s approximately 70 per cent of health spending went on hospitals (this includes long-stay hospitals). It is worth noting that in 1960 public expenditure on health accounted for 2.9 per cent of Irish GNP – a higher percentage than France, (2.6%), Belgium (2.0%); and The Netherlands (1.8%), and only

[22] *The Health Services and their future redevelopment*, p. 36.
[23] *Dáil Debates*, vol. 192, 23 November 1961, cols. 724-6.
[24] The figure given by Brendan Corish: *Dáil Debates*, vol 192, 23 November, Col. 773.
[25] *The Health Services and their future redevelopment,* pp. 39-40.

fractionally lower than Germany and Denmark both at 3 per cent.[26] While GNP per capita in Ireland was much lower than in the comparator countries, this suggests that, while state funding for GP, home-care, drugs and other non-hospital services was low, funding for the hospital sector was not inadequate – whether that money was well spent is another question. Tom Feeney notes that the Irish health system of the early 1960s was widely considered to be 'unwieldy and inefficient'. [27] I would not disagree.

So what was the hospital system like? The 1920s brought pressures throughout Europe for a rationalisation and consolidation of the many small hospitals that existed, especially in cities. The Great War of 1914-18 resulted in a sharp rise in inflation and significantly higher taxes on capital and the incomes of the rich: thus the value of the endowments that supported many charitable hospitals collapsed. The increasing medicalisation of hospital care also created pressure for mergers and the construction of new hospitals: older, smaller hospitals could not afford x-ray machines, anaesthetists or the resources to provide blood transfusions. Modern hospitals required proper electrical services, more operating theatres, lab spaces etc. In Britain 'many of the large voluntary hospitals were only saved from bankruptcy through municipal subsidies, which cost them a degree of autonomy, bringing them under the control of local health authorities'.[28] This ultimately made it easier in Britain to rationalise hospitals under the National Health Service. Likewise in France where voluntary hospitals also became dependent on municipal funding which made it easier to close or merge hospitals. [29]

Accepting the fact that the twentieth century brought about a major expansion of hospital medicine internationally, the question stands: what was different in Ireland? In Ireland it might have been expected that many voluntary hospitals should have collapsed after 1920, especially those hospitals which relied on the patronage of the Anglo-Irish. This did not happen; on the contrary by the 1930s Irish voluntary and public hospitals had embarked on elaborate building programmes and a spending spree, thanks to the Irish Hospitals' Sweepstake. The Sweepstake was originally

[26] Statistics taken from Department of Health figures, given in Tom Feeney, *Seán MacEntee. A political life* (Dublin, 2009), footnote 62, p. 224.
[27] Tom Feeney, *Seán MacEntee. A political life*, p. 211
[28] Porter, *Health, civilization and the state*, pp. 214, 5.
[29] Lawrence, 'Continuity in crisis: medicine, 1914-45,' p. 352; Christian Chevandier, *L'Hôpital dans la France du XXe siècle*, (Paris, 2009), pp 168-71.

established to fund the Dublin voluntary hospitals, but within a short period, it was also financing the construction and expansion of county hospitals and auxiliary services such as Mother and Baby Homes. Income far exceeded expectations; by 1931 the Sweepstake was providing £1m. for Irish hospitals, at a time when total public spending on all forms of public health and public assistance (including state payments to the uninsured poor) was approximately £3m. With such ready money available, the participating hospitals began to indulge in what Seán MacEntee described as 'haphazard expenditure'[30] – lavish spending programmes, new buildings and equipment, in an effort to maximise their take from the fund. The 1933 Public Hospitals Bill gave responsibility for allocating Sweepstake money to the Department of Local Government and Public Health, and made the money available to the entire hospital sector (much to the annoyance of the Dublin voluntary hospitals who had originated the Sweepstake).

Money was allocated by the Hospitals Commission (established in 1933) and initially they attempted to use the Sweepstake to close and restructure hospital services. In Dublin the Hospitals Commission proposed to create four major hospitals (two north of the Liffey, two on the southside) in place of the many small hospitals that existed. Outside Dublin they planned a network of modern county hospitals, linked to regional centres that would provide more specialist care. Yet this is an instance where the large sums of money available prevented reform: the income from the Hospitals Sweepstake protected the voluntary hospitals from financial disaster, postponing reform, because the Hospitals Commission repeatedly met their deficits. As for county hospitals capital funding was readily available for new or expanded buildings, but less attention was paid to creating a coherent regional system. The unwillingness of the state to intrude too far into the voluntary hospitals for fear of antagonising denominational interests – is an important part of this story,[31] but too much soft money, and political patronage – constructing a new county hospital or expanding the hospital was popular with the electorate – was also a factor. Paradoxically, this is a case where less money would have facilitated reform. If capital funding for hospitals had been less readily available; if expectations of unlimited funding had been lower (because the lavish capital spending

[30] *Dáil Debates*, vol 38, 20 May 1931, Public Charitable Hospitals Amendment Bill, col. 1475.
[31] Mary E. Daly '"An atmosphere of study independence". The state and the Dublin hospitals in the 1930s', in Elizabeth Malcolm and Greta Jones, (eds), *Medicine, disease and the state in Ireland, 1650-1940*, (Cork, 1999) pp. 234-52.

continued after the golden age of the Sweepstake had ended), there might have been fewer new beds and smaller hospitals might have closed.

By 1947 expenditure on hospital construction had reached £7m – most of this was carried out before 1940 when building supplies virtually dried up.[32] By the end of the Second World War voluntary hospitals were running annual deficits of £200,000 – which were covered by the Hospitals Trust. There is no evidence of any effort to control these deficits – there was no incentive. Prudent management suggested that a capital reserve from the Sweepstake should be built up to finance these deficits and the additional running costs associated with new hospitals and additional beds, but Noel Browne thought otherwise. When Browne became Minister for Health in 1948 he found requests for 135 hospital building projects, costing £27m on his desk; he reduced this to £15m – to be funded by running down the capital of the Hospitals Trust; by the end of 1949, post-war inflation had raised the costs of the approved building schemes to £26m. According to Marie Coleman, Browne reassured officials that they 'need not have qualms about the necessary funds becoming available'. Good news for all, because by 1952 the cost had risen to £35.5m. By then the reserve of the Hospitals' Sweepstake had been exhausted and spending was running far ahead of income, with the result that the government was supplementing the Hospitals Trust Fund from the Exchequer.[33] Although the Exchequer was now picking up a growing share of the cost, spending continued apace; there appears to have been a belief that the Sweepstake would soon return to its pre-war financial state; it didn't.

Most developed western countries embarked on a hospital building programme after the Second World War, however, this did not necessarily result in a significant increase in the number of beds; there was only a marginal increase in beds per capita in Britain and the US from 1945 to 1970.[34] In Ireland, the number of beds rose, without any

[32] Marie Coleman, *The Irish Sweep. A history of the Irish Hospitals Sweepstake,1930-1987*, (Dublin, 2009), p. 204.
[33] Coleman, *The Irish Sweep*, pp. 207-10.
[34] Anne Hardy and E.M. Tansey 'Medical enterprise and global response 1945-2000', in W.F. Bynum, Anne Hardy et al. *The Western medical tradition. 1800 to 2000*, (Cambridge 2006), p. 441.

obvious effort to estimate future demand or collect comprehensive data on bed usage.[35] Between 1949 and 1956, 4,000 tuberculosis beds, 2,400 general medical and surgical beds, 176 maternity, 200 orthopaedic and 450 children's hospital beds were added, and specialist medical services such as paediatrics, obstetrics, pathology and radiology were extended nationally, and in provincial hospitals.[36] These beds were added without any serious effort to close existing hospital beds. Dublin's network of voluntary hospitals, many within walking distance of one-another survived largely unchanged, as did the voluntary hospitals in Cork, and Limerick; county hospitals expanded and duplicated services such as obstetrics and paediatrics, available nearby.

A key component in the Browne hospital programme was the provision of sufficient beds in dedicated TB hospitals to meet the Irish epidemic, but even before many of these hospitals left the drawing board, the emergence of an effective chemotherapy – streptomycin – had transformed TB treatment. Yet the construction of additional beds for TB patients continued. In Galway, for example, the Hospitals' Trust funded the construction of operating theatres at Woodlands – a TB hospital dating from the 1920s; the theatres came on stream in 1952. In the same year the first phase of Merlin Park – a modern TB hospital opened a short distance away. Yet despite empty beds in Merlin Park, construction continued; the additional TB treatment units did not open until 1954, by which time they were definitely surplus to requirements. By 1958 all orthopaedic cases in Galway (including many patients from throughout the west of Ireland) had moved into two unused ward blocks at Merlin Park – though it was not built as an orthopaedic hospital; by 1961,120 beds in the 550 bed hospital were being used for long-term geriatric care.[37] Long-term geriatric care occupied many underused beds in acute hospitals or TB hospitals.

Thanks to the Hospitals' Sweepstake Irish county hospitals had plenty of beds in modern wards, but the hospitals were often too small to justify specialist appointments. Initially a county hospital – the cornerstone of the hospital service in provincial Ireland

[35] I have failed to find reliable data giving the total number of hospital beds, types of hospital bed, numbers treated etc. during the 1950s. The voluntary hospitals and the county hospitals were treated by the government as distinct entities.
[36] Barrington, *Health medicine and politics in Ireland*, p. 249.
[37] James P. Murray, *Galway : a medico-social history*, (Galway, no date), pp. 179-80.

– had one senior position – a consultant surgeon. In time he was joined by a consultant physician, and these two senior professionals were designated as County Surgeon and County Physician. Radiologists and anaesthetists were part-time posts, moving from hospital to hospital, and there was no resident pathologist. The surgeon was also responsible for obstetric and gynaecological cases. Most county hospitals admitted children, who were either seen by the general surgeon or physician, or waited for a weekly or fortnightly visit by a paediatrician. County hospitals often lacked adequate laboratories, and radiological facilities; this meant that patients had to remain in hospital longer than necessary – for the weekly or bi-weekly visit of the radiologist or anaesthetist, or while laboratory results came back from a regional hospital. [38] So there is little mystery why hospital stays were lengthy.

A further complication was the existence of two separate hospital systems: local authority hospitals and voluntary hospitals, which were not required to co-operate on services, staffing or patient treatment and often failed to do so. The Fitzgerald report described 'a tendency to reduplicate services excessively'. [39] Hospitals who persisted in lobbying the Hospitals' Commission (and probably local TDs) were generally given approval for a new lab, a new X-Ray machine, even though there was underused capacity in a nearby hospital. J.B. Lyons noted that during the 1950s the governors of Mercer's Hospital 'were accustomed to being heavily in debt to the bank with the tacit assurance that sooner or later the Hospitals Commission and the Department of Health would reduce the deficit. A comfortable situation, perhaps, enabling them to face spiralling costs with equanimity and pay due attention to demands from trade unions. . . The system of deficit budgeting was surely a betrayal of economics'. [40] Mercer's was not a-typical. The annual deficit of voluntary hospitals almost doubled between 1954 and 1958 – from £656,000 to £1.125m,[41] at a time of economic crisis when public spending was under acute pressure. By the late 1960s voluntary hospitals were running a combined annual deficit of approximately £5m., which was underwritten by the Hospitals Commission.[42] But the end was nigh because falling revenue from the

[38] Fitzgerald Report, p. 17.
[39] Fitzgerald Report, p. 41.
[40] J.B. Lyons, *The Quality of Mercer's. The story of Mercer's hospital 1734-1991*, (Dublin, 1991), p. 159.
[41] Coleman, *The Irish Sweep*, p. 215
[42] F.O.C. Meenan, *St. Vincent's Hospital 1834-1994. An historical and social portrait,* (Dublin, 1995), p. 152.

Hospitals' Sweepstake was forcing a tougher attitude. A key moment for Dublin voluntary hospitals appears to have been the refusal of the Department of Health to approve the construction of a pathology lab at Mercer's Hospital. [43] In the late 1950s seven voluntary hospitals in Dublin began to talk about a merger, and in 1961 legislation was passed, creating a central council that would control all capital expenditure and all future appointments to the medical staff across these hospitals. One of the earliest initiatives was to centralise pathology services across the seven hospitals. Lyons noted that the centralisation of pathology services improved the diagnostic services immeasurably though clinicians rather regretted that they were no longer able to drop into the laboratory to discuss the significance of this test or that with the pathologist'. [44]

The wider hospital sector, and its shortcomings were scrutinised in the 1968 Fitzgerald report, which described the Irish hospital sector as 'outmoded and (is now) a hindrance to good medicine'. The report concluded that 'the requirements of a modern hospital services have become so complex that we can only meet them by a radical re-organisation of our hospital system involving, inter alia, a considerable reduction in the number of centres providing acute treatment.[45] Fitzgerald proposed to consolidate acute hospital services in twelve locations in Ireland, with sixteen large hospitals, each with a full team of specialist services; county hospitals not identified as one of these centres would become 'community health centres'.[46] The proposals resulted in vociferous protests from many local authorities and local interest groups, with special meetings of local authorities called to denounce the proposals. Members of the Old IRA held a fast and vigil outside Roscommon County Hospital – one of the affected hospitals. In 1972 the local hospital action committees came together to form a National Hospitalisation Organisation.[47] County surgeons and county physicians defended their status against the demand for sub-specialism, and county hospitals continued to press for additional resources, complaining about decisions to prioritise hospital construction in Cork and Dublin, in order to provide specialist treatments: 'What hospital in Dublin

[43] Lyons, *Quality of Mercer's*, p. 160.
[44] Lyons, *Quality of Mercer's*, pp. 163-5.
[45] Fitzgerald Report, pp. 16-17.
[46] Fitzgerald Report, p. 31.
[47] *Irish Times*, 7 August 1972, 1 August 1972.

ever has up to five per cent of its patients accommodated on stretchers on the floor? Accommodation, staffing and facilities in general in country hospitals lag very far behind those in Dublin and the State has a duty to remedy these defects urgently. We are all Jock Tamsan's bairns'. It is extremely difficult to reconcile this statement by the county surgeon in Wexford with statistics in the Fitzgerald report showing that bed occupancy in Wexford was well below the national average, and the average stay of patients well above the national average. [48]

The 1970 Health Act created regional health boards, with the goal of creating coherent health services on a regional and not a county basis. However, the Act perpetuated, what I would see as the systemic bias of state-funding in favour of the hospital sector, because it continued albeit in a new form, the two-tier health system with free outpatient GP care provided only for the poorest 30 per cent or so of the population, which was, approximately the proportion entitled to free care under the dispensary system. The remainder of the population had to pay the cost of GP visits and associated costs, whereas hospital treatment continued to be highly-subsidized or covered by the VHI.

[48] *Irish Medical Times*, 6 April 1973.