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A European late starter –

Lessons from the history of reform in Irish health care

1. Introduction

The Irish healthcare system is unusual within the European context, since it is not designed with the objective of offering universal, equitable access to either primary or acute hospital care. A complex mixed public-private system persists despite much criticism and repeated reform attempts since before the foundation in 1922 of the independent Irish state and over the 95 years since independence. In 2011, a newly-elected government made an historic commitment to the development of a universal, single-tier health service, to be funded by Universal Health Insurance (UHI)(Department of the Taoiseach 2011). The proposed reforms were abandoned in 2015, in part due to concerns about the cost implications of the proposed UHI model. Following a general election in 2016, the new Government’s programme outlined steps required to research the best path to universal healthcare (UHC) (Department of the Taoiseach 2016). An all-party parliamentary committee was established with the aim of achieving “a single long-term vision for healthcare and the direction of health policy in Ireland” (Dail Debates 2016). Health policy in Ireland therefore currently stands at a crossroad.

Ireland can be viewed as a late starter within Europe in progressing to a universal healthcare system. From the introduction of compulsory social insurance for healthcare in Germany in the late 19th century, Ireland's neighbouring European states have gradually embraced variants of universality in healthcare, most notably from the 1940s (Thomson et al. 2009; Council of the European Union 2006; Wren 2003). Notwithstanding Ireland's status as part of the United Kingdom up to 1921, the Irish healthcare system already diverged from the UK system prior to independence, with resistance to reform emerging from a uniquely Irish combination of Catholicism and medical politics (Barrington 1987; Wren 2003). While the European Union (EU) has accepted 'the overarching values of universality, access to good quality care, equity and solidarity' as 'the common values and principles that underpin Europe's health systems' (Council of the European Union 2006, 1), this statement cannot validly be applied to the Irish system, which remains an outlier within the EU.

The aim of this paper is to examine health system reform in Ireland, focusing on previous reform proposals and applying some of the lessons from this history in discussing new avenues of reform. This paper adopts an historical institutionalist approach to develop an understanding of the long-term processes which have contributed to Ireland remaining a European outlier in its failure to develop a universal healthcare system (Pierson and Skocpol 2002). This examination of the role of institutions and temporal processes in shaping the politics of healthcare in Ireland and the nature of the Irish healthcare system focuses particularly on the roles played by the Church and organised medicine; on the nature of the

relationships between Church, society, economy and the independent Irish state; and on the critical junctures when reform attempts failed and to which the roots of the modern Irish healthcare system can be traced.

The next section will provide a brief overview of the current Irish healthcare system and identify the characteristics of this system which are incompatible with universality and equity; Section 3 will review the historical and institutional background to attempts to introduce reform from 1911; Section 4 will discuss the 2011 proposals for reform; Section 5 will apply lessons from this history in discussing the current search for a new policy direction; Section 6 concludes.

2. The Irish healthcare system

Ireland's healthcare system is characterised by a complex mixture of public and private delivery and financing and multiple eligibility tiers, which govern access to care. Ireland has the only European health system that does not offer universal coverage of primary care (Thomson et al. 2012). The system is predominantly tax-financed (69 per cent) with out-of-pocket (OOP) payments contributing 15 per cent to overall financing and private health insurance (PHI) contributing 13 per cent in 2014 (Central Statistics Office 2016). PHI purchases preferential access to hospital care despite its relatively low financing contribution, and approximately one-third of general practitioner (GP) primary care is financed by OOP payment of fees (Wren et al. 2015). From 2004 to 2012, in a period spanning years of financial crisis in Ireland, there is evidence that the tax-financed share declined while OOP and PHI shares

increased (Wren et al. 2015). Comparison between the financing composition in 2014 and earlier years is not possible, however, due to changes in health accounting methods. High salaries and drug prices contribute to underlying cost pressures in the system (Thomson et al. 2012). Irish current healthcare expenditure has exceeded the OECD average as a percentage of GDP since 2008 and was estimated at 10 per cent of GDP in 2014. Ranking Irish healthcare expenditure for international comparative purposes is challenging, since GDP is an over-stated measure of national income due to the repatriated profits of the large multi-national sector and national health care accounts may over-estimate healthcare expenditure due to the inclusion of funding for social programmes.

Notwithstanding increased healthcare expenditure, there is evidence of financial barriers to access, unmet need for care and relatively high user charges for primary healthcare (O'Reilly et al. 2007; Kringos et al. 2013). A minority of the population qualifies for medical cards on grounds of low income, or older age and low income combined. Medical cards give access to all forms of care without charge, with the exception of a charge for prescribed medications. A further category of card (GP-visit card), also accessed on age or income grounds, removes the need to pay fees for visits to GPs. The majority of the population must pay OOP fees for GP visits. Irish OOP fees are at the full market rate set by self-employed GPs, which are high compared to co-payments in other countries (Kringos et al. 2013), and there is evidence that they deter necessary medical visits (O'Reilly et al. 2007).

In 2015, 46 per cent of the population purchased private health insurance (MillwardBrown 2016), which is largely intended to ensure timely access to care, whether in public or private hospitals. Hospital consultants may hold contracts which permit them to conduct private practice in public hospitals, for which they earn private fees on top of their public salaries; while public hospitals also earn additional income from treating private patients. Although a nominally common waiting system was introduced in 2008, privately insured patients' faster routes of access to initial consultations in consultants' private rooms and to diagnostic tests, ensure that they gain faster access to public hospital elective care while public patients can experience long waits (Tussing and Wren 2006; Department of Health 2016). Additionally, privately insured or paying patients can access the private hospital sector, which expanded rapidly in the early 2000s supported by Government subsidies (Tussing and Wren 2006).

While definitions of universality differ, the "universal coverage cube", adapted from a concept developed by Busse et al. (2007) as a framework for the definition of universality, has been adopted by the World Health Organization (WHO) to monitor its achievement. The cube identifies three dimensions of universality – population coverage, service coverage and cost coverage (Kutzin 2013; World Health Organization 2010). By pooling funds (through taxation, social insurance or some other means), universal systems aim to remove financial barriers to accessing care. The extent of financial protection and universal coverage then depends on the proportion of necessary services that are financed from the fund; the breadth of population coverage; and the extent of the removal of out-of-pocket payments

required to access necessary healthcare (Wren and Connolly 2016). Using this framework of analysis, it can be seen that the Irish healthcare system fails to protect the majority of citizens against financial barriers to accessing primary care.

Furthermore, the dual system of state-supported private care in public and private hospitals with rationed public hospital care, fails to ensure access to elective hospital care in need for those who cannot afford private health insurance or private fees.

3. Historical and institutional background

The Irish healthcare system's characteristics of financial barriers to accessing primary care and inequitable, "two-tier" access to hospital care have survived through a long history of opposition to reform, pre-dating the independent Irish state. Common throughout the period from 1911 to 2011 was a fundamentally libertarian perception of healthcare as a marketable commodity rather than a right (Smith and Normand 2011; Wren 2003). Ten years before Irish independence, in 1911, the Catholic Church and some in the medical profession, with the support of Irish representatives at the UK's Westminster parliament, successfully opposed extension to Ireland of a medical benefit system funded by social insurance, to provide free GP care and medications, which was introduced in the rest of the UK (Barrington 1987).

A key factor in the divergence of policy on healthcare in Ireland from other developed states was the powerful position of the Catholic Church, espousing a particularly conservative brand of Catholicism, which had become equated to nationalism in the long Irish struggle for independence. Although the independent Irish state came into being in 1922 after a war of independence, there followed a

bitter civil war fought over the terms of independence and the political revolution did not herald the changes in state or class structures which characterise social revolutions (Skocpol 1979; Breen et al. 1990). The independent state retained the state apparatus inherited from the British colonial government, the post-colonial society retained its traditional suspicion of government and the new government had a minimalist concept of its role (Breen et al. 1990). The weak State left political space for the Catholic Church to occupy. The Church delivered and controlled much of education and health and social services. Since the 19th century, Ireland had a tradition of Catholic Church-founded and controlled hospitals, funded by charitable endowment, augmented by grants from parliament and from 1930 by a national lottery (Barrington 1987), and funded in the modern era by taxation and private health insurance.

Catholic social teaching was suspicious of state activity, shaped the attitudes of Irish politicians and influenced the 1937 Irish Constitution, which gave explicit recognition to the role of the Church (Breen et al. 1990). Ireland of this era has been compared to Spain and Portugal in its commitment to maintaining a Catholic, rural society (Crouch 1993). While after the Second World War, Catholic political parties in many European states were either left-wing or prepared to ally themselves with socialists in supporting the development of the welfare state (Whyte 1980), in Ireland the Catholic Church was fearful of socialism or of reforms which would dilute Catholic control of healthcare institutions and sexual morality (Wren 2003). The emphasis on sexual morality in the Irish Catholic Church has been interpreted as at least in part the consequence of the famines of the 19th century which provoked a societal

response of celibacy and late marriage to avoid the sub-division of farms (Daly 1981) and exacerbated population decline - from 8.2 million in 1841 to 4.4 million in 1911.

A further factor which contributed to the divergence of health policy in Ireland from the European mainstream was the political party system which developed post-independence. The independent state was relatively rural with only 13 per cent of the labour force engaged in industry in 1911 (Kennedy et al. 1988); Northern Ireland was more industrial but remained within the UK, splitting the emerging labour movement (Daly 1981). The Irish case is seen as an exception to the models of party systems that apply across Europe (Mair 1999). Politics in the independent Irish state has been dominated by two political parties (Fianna Fail and Fine Gael) which, as in the US party system, have their roots in allegiances from a schismatic civil war, and have cross-class appeal (Mair 1999). Their dominance has prevented the emergence of the reforming, class-based politics which fostered the growth of welfare states internationally.

As the political party system so too the welfare state in independent Ireland eludes categorisation. While in other European countries Catholic-party strength has been associated with the development of conservative welfare regimes, such as in Germany or Austria (Esping-Andersen 1990), Ireland lacked the critical historical accompaniment for their development of an absolutist State. Insofar as Ireland fits into one of the three worlds of welfare capitalism, its means-tested benefit system and modest social transfers suggest it could be placed among liberal welfare regimes (Esping-Andersen 1990). However, were equity in and access to healthcare the

criteria, Ireland has little in common with other such liberal regime states like Canada and the UK.

Without a tradition of mainstream social democratic or secular politics, Irish political parties were deferential to Catholic Church leaders until the final decades of the 20th century (Whyte 1980; Browne 1989; Wren 2003). In France and the UK in the post-war years, comprehensive healthcare systems developed funded by social insurance and taxation respectively with roots in the occupational health insurance systems, which had developed in the 1920s. But in Ireland the combination of weak State and powerful Church obstructed reform at a critical juncture. When the UK's introduction of a comprehensive free national health system (NHS) in 1948 encouraged reform proposals from Irish politicians and government officials, an alliance of Church and doctors prevented introduction of a proposed "Mother and Child" scheme in 1951, which would have offered free primary care to children and free care to mothers before and after birth (Whyte 1980). In a letter to Government in 1950, Catholic bishops argued against introducing free primary care for children in Ireland on the grounds that the right to provide for the health of children belonged to parents not to the state which should not "deprive 90 per cent of parents of their rights because of 10 per cent necessitous or negligent parents" (Browne 1989).

Thus, the medical profession which feared state employment and loss of private fee income, found an ally in the Catholic Church in impeding reform up to the 1950s.

Medical opposition to state healthcare was also a feature of the reform process in other countries: the establishment of the NHS met medical resistance in the UK in

the 1940s (Foot 1973); and, in the Canadian province of Saskatchewan in 1962, doctors went on strike in opposition to the introduction of compulsory health insurance (Taylor 1987). However, while democratic politics prevailed in the UK and Canada, this was not the case in Ireland.

Paradoxically, within the same decade as the critical “Mother and Child” defeat the concept of the role of the State fundamentally altered and broadened in 1958 with the introduction of economic planning and opening up to foreign investment in response to economic stagnation and mass outward migration (Breen et al. 1990). Furthermore, influenced by progressive social thinking in the wider church which in the 1960s had come to view healthcare as a human right (Catholic Church 1963), the Catholic Church in Ireland became an advocate of healthcare reform from the 1970s (while continuing to seek to control sexual morality and applying Catholic ethics in hospitals under its control). The medical profession, however, remained opposed to reforms which would remove private fee income, with hospital consultants preventing the introduction of free hospital care by threatening to strike in 1973 (Wren 2003). In an echo of 1951, government was unwilling to use State power to face down opposition to reform.

Ireland underwent rapid economic and social change in the final three decades of the 20th century: industrialisation raised national income – more people were employed in industry than agriculture for the first time in 1969 (Daly 1981); access to education improved; EEC membership in 1973 increased awareness of other social models. By the late 1970s, the former ageing and decline in population had been

reversed and the Irish had the youngest average age in Europe. Irish GNP per capita, estimated at 60 per cent of the UK's in 1913 (Kennedy et al. 1988), converged to the EU 15 average in the early 2000s (FitzGerald 2006). Yet, notwithstanding the rapid economic and social change, the nature of Irish politics remained inimical to fundamental reform in healthcare. In a further parallel with the US, where patronage-oriented politics impeded the development of a welfare state (Skocpol 2008), clientelist politics in Ireland, where the voting system elevates local concerns over national (Garvin 1999), did not promote the emergence of a universalist agenda in healthcare.

With increased national income, government expenditure in general and on health increased in the 1970s and 1980s although a fiscal crisis in the late 1980s provoked cutbacks to healthcare expenditure. Nonetheless in response to campaigning by the trade union movement, free hospital care becoming nominally universal from 1991 (Wren 2003). However, "two tier" access was further institutionalised with the retention of public hospital consultants' rights to earn private fee income in public hospitals and work simultaneously in public and private hospitals, combined with the growth of private health insurance in response to the cutbacks in public care (Wren 2003). The focus of government reform attempts on reducing financial barriers to hospital care, while failing to address such barriers to primary care, resulted in the development of a particularly hospital-centric model of care and under-developed primary and community care (Ruane 2010; Thomson et al. 2012).

Ireland's economic transformation was based on market solutions (Breen et al 1990) and openness to market solutions in healthcare increased with the participation in

coalition governments of the influential, albeit small Progressive Democrat (PD) party. Founded in 1985, the party advocated reduced taxation, deregulation and privatisation, inspired by the agenda of Reagan and Thatcher (Wren 2003).

Government tax subsidies from the early 2000s promoted the growth of for-profit, private hospitals (Tussing and Wren 2006). Opening the formerly state-provided private health insurance industry to competition promoted the growth of tax-subsidised for-profit, private health insurance (Tussing and Wren 2006; Wren 2003).

The combination of insurance-funded and fee-for-service reimbursed private medicine with rationed and hospital-centric, public healthcare has given rise to a complex system of perverse incentives that mitigate against equitable delivery of care prioritising medical need (Tussing and Wren 2006). Although there has been a significant recent movement to support for health system reform within the medical profession (Irish Medical Organisation 2010), the growth of private health insurance gives almost half the population preferential access to hospital care, which has created a potential large voting bloc in favour of the status quo.

The first Irish Government to re-espouse the aim of the Mother and Child scheme of 1951 of removing fees for GP care for children was the Government elected in 2011 – 60 years later (Wren and Connolly 2016). It is hard to overstate the historic nature of the 2011-2016 Programme for Government, which committed to a healthcare system ‘designed according to the European principle of social solidarity: access will be according to need and payment will be according to ability to pay’ (Department of the Taoiseach 2011, 31). The programme proposed to end two-tier access to hospital care and introduce GP care free at the point of use for all in a system financed by

UHI. This 2011-2016 Government achieved an extension of free GP care to children aged under six and people aged 70 and over, while the successor Government elected in 2016, has committed to extending free GP care to young people up to the age of 18 (Department of the Taoiseach 2016).

The election of a Government committed to such a fundamental reform was the culmination of a decade of development of evidence and policy in favour of reform. Evidence supporting movement from payment at the point of use to pre-payment (financed by tax or insurance) was presented by an expert advisory group appointed by Government (Brick et al. 2010; Ruane 2010). A case for social insurance funding of a universal healthcare system in Ireland was proposed in a series of studies (Thomas et al. 2006, 2008,2010). Policy documents published by the two opposition parties who entered government together in 2011 proposed reforms to introduce insurance-financed, universal healthcare. The larger party in Government, Fine Gael, evolved a policy proposing a UHI model financed via competing private insurers based on the 2006 reforms in the Netherlands (Fine Gael 2009). The smaller Labour Party proposed a UHI model in which hospital care would be financed via multiple, largely public insurers and primary care would be financed by social insurance, with the primary care reform preceding the hospital reform (The Labour Party 2011). The 2011 Programme for Government was a compromise between these two policies, and its interpretation caused discord in Government (Loughlin 2016a; Dail Debates 2012).

After a century in which healthcare reform attempts by a weak State were defeated by Church and doctors, followed by the evolution of a stronger State promoting market-based solutions to the development of healthcare, there had emerged for the first time a comprehensive Government healthcare reform programme, explicitly based on the European value of social solidarity. Yet within the Government there remained tensions between supporters of the market-based model favoured by Fine Gael and the more social democratic model favoured by the Labour Party.

4. Reform proposals – towards universality?

The historic nature of the commitment to universality in the 2011 reform proposals is underlined by the continued support for the objective of universality of the all-party parliamentary committee established in 2016 (Houses of the Oireachtas Committee on the Future of Healthcare 2017). This section therefore discusses in greater detail the reforms proposed in 2011 and abandoned in 2015 due to cost concerns at a time when Ireland was struggling to emerge from fiscal crisis. Under an elaboration of the proposals in a 2014 White Paper, UHI would finance aspects of primary and hospital care, while programmes such as long-term and community care for older people would remain tax and OOP-financed (Department of Health 2014). Every member of the population would be insured for the same package of healthcare services, with individuals purchasing insurance for this standard package from one of a number of competing health insurers. Financial support would be available to ensure affordability by directly paying or subsidising from taxation the cost of insurance premia for people on lower incomes.

The multi-payer competing insurer model outlined in the White Paper was, to a large extent, based on the model favoured by Fine Gael of health insurance in the Netherlands, where private health insurance became mandatory for all in 2006. However, the applicability of this model to Ireland was questioned even as the policy gained political support. Ryan and colleagues, for example, noted that a successful shift to a Dutch financing system could result in a more equitable healthcare system but questioned whether the Irish health system has the requisite capacity (Ryan et al. 2009). The Dutch model is predicated on achieving meaningful competition with insurers selectively contracting with healthcare providers. Such selective contracting is relatively rare in the Netherlands (Bal and Zuiderent-Jerak 2011) and even more of a challenge in Ireland due to lower population density and few major hospitals outside urban centres (Mikkers and Ryan 2014).

The 2014 White Paper provided little detail on the potential cost implications of the proposed reforms, although it suggested that spending by the state on healthcare under a single-tier UHI system should not exceed spending under the two-tier system which it replaced. The White Paper proposed a number of cost control measures and propounded that multiple competing payers would encourage insurers to reduce their costs and premiums to attract more customers (Department of Health 2014). However, the available evidence does not readily support the assertion that competing insurers lead to a reduction in costs (Hsiao et al. 2011; Lu and Hsiao 2003; Mathauer and Nicolle 2011). While the rationale for competition is increased efficiency, the level of competition is often limited so that the anticipated effect is not observed in practice (Mathauer and Nicolle 2011; Thomson et al. 2013).

Evidence from the Netherlands suggests that following attempts to control healthcare costs by encouraging price competition between insurers, while insurers were successful in reducing their operating costs, these costs amounted to only 7 per cent of insurers' expenses (Rosenau and Lako 2008).

Although the 2011 Programme for Government committed that the UHI system should be designed to remain outside the remit of EU competition law (Department of the Taoiseach 2011) as is the case in many European systems of statutory social insurance (Prosser 2010), subsequent unpublished legal advice to the Minister for Health concluded that competition law would continue to apply to private health insurers within the UHI system (Lynch 2014). If competition law would apply, this would reduce the control government would have over factors such as pricing, cost control and insurers' margins (Wren and Connolly 2016). The distinction in ensuring that a system is outside the scope of EU competition law is that it should be designed according to principles of social solidarity with equal access to services irrespective of ability to pay (Prosser 2010).

In November 2015, a report was published detailing the potential cost implications of the proposed model (Wren et al. 2015). Due to a lack of detail about the proposed reform, the analysis adopted assumptions about aspects of the model including what basket of services would be financed by UHI and the additional costs associated with financing healthcare through multiple, competing insurers under EU competition law. The analysis estimated that the proposed model of UHI would increase healthcare expenditure in Ireland by between 3.5 and 10.7 per cent per annum

(Wren et al. 2015). While some financing reforms may merely shift financing from one source to another, e.g. from OOP fees to public financing via social insurance or taxation, this analysis found that there would be additional healthcare expenditures as well as shifts in the sources of financing. The major contribution to additional costs was projected to arise from private insurers' margins on expenditures financed by PHI which were formerly financed by taxation or out of pocket. A further source of additional expenditures would arise from the expansion of services required to address unmet need under the current system (Wren et al. 2015).

Following publication of the costing analysis, the Minister for Health announced that “the high costs for the particular model of health insurance ... are not acceptable, either now or any time in the future”(Department of Health 2015). Subsequently, this model of UHI disappeared from the political agenda. The rejection of the model on cost grounds alone curtailed debate on any offsetting merits that the model might have, on other deficiencies in its design or on adaptations that might reduce the costs or address other deficiencies. For example, while the proposed model of UHI envisaged full coverage of the population, the extent of services to be included was unclear, as was the extent to which out-of-pocket charges would remain (Wren and Connolly 2016). In addition, the White Paper model stated that insurers would be free to engage in selective contracting with healthcare providers, which would allow insurers to offer different types of UHI policies, offering a greater or lesser choice of healthcare providers, and with differing levels of unreimbursed excess (Department of Health 2014), but provided no detail about how this aspect of the

model would be reconciled with provision of equal access based on need rather than ability to pay.

The 2016 election made clear that in Ireland as in other European countries, austerity measures during the fiscal crisis had reduced support for established political parties and increased support for smaller left-wing parties and independents. Although the Taoiseach (Prime Minister) was re-elected to head the incoming 2016 Government, the minority government of Fine Gael and independents requires support or abstention from opposition deputies to pass any legislation which has increased the power of the legislature relative to the Government (Loughlin 2016b). Reflecting this shift in power, an all-party parliamentary committee (Committee on the Future of Healthcare) was established with the aim of achieving a single long-term vision for healthcare and the direction of health policy in Ireland. The Committee's final report, published in May 2017, recommended the introduction of universal GP and primary care, ending private practice in public hospitals, reducing or removing OOP fees and substantially increasing public healthcare expenditure and capacity in a tax-funded system (Houses of the Oireachtas Committee on the Future of Healthcare 2017). Despite its cross-party membership, the adoption of its recommendations by Government is not a foregone conclusion. The major political parties achieved the report's amendment to include a proposal for an independent analysis of any "adverse and unintended consequences" arising from the removal of private practice in public hospitals (Houses of the Oireachtas Committee on the Future of Healthcare 2017; Leahy 2017b). Earlier, a proposal to remove tax subsidies for private health insurance was

opposed by government ministers and voted down in the Committee (O'Connor and O'Regan 2017).

5. Applying lessons from the past to the search for a new policy direction

For the first time since the foundation of the independent Irish state, there appears to be a strong political commitment to achieving universal healthcare in Ireland, although the path to achieving universality is still a topic of debate. While identifying a path to universality for Ireland is beyond the scope of this paper, the history of defeated reforms in Ireland offers lessons for progressing to a universal healthcare system. These lessons can be broadly categorised under the headings of the challenge of addressing potential opposition to reform from stakeholders such as medical professionals and the privately insured; and the related challenges of achieving clarity on the definition of UHC for Ireland, broad support for its achievement and a feasible and efficacious approach to reform.

The history of Irish reform attempts suggest that challenges to implementation which may arise include stakeholder opposition. Although the Catholic Church no longer opposes reforms to achieve universality in Irish healthcare, it retains hospital ownership and may veto procedures in its facilities which are deemed to conflict with Catholic ethics (Wren 2003). In 2017, church-state controversy again emerged in the politics of Irish healthcare, as following resignations by senior clinicians, the government was forced to review its acquiescence to Church ownership of a new maternity hospital to be financed by state capital investment (O'Connor 2017).

While the Church may no longer challenge reform, stakeholder opposition to attempts to achieve universality may arise from provider and societal attachment to a private market in healthcare. The history of reforms in the UK and Canada suggests that successful reform may require strong political leadership and a willingness to withstand medical opposition (Foot 1973; Taylor 1987). While there appears to be a political commitment to universal healthcare in Ireland, that commitment will require the will to overcome potential opposition from sections of the medical profession, who were so potent in the defeat of reforms in the 1950s and 1970s. Although the introduction of free GP care for children aged under six years in 2015 was opposed by some GP organisations (Goodey 2015), with primary care capacity a concern, this did not prevent the introduction of this reform. However, the parliamentary committee appeared influenced by this stakeholder perspective in its 2017 final report, describing GP capacity as “exhausted”.

Addressing two-tier access to the public hospital system would require revision of the historically challenging hospital consultants’ contract of employment. Hospital consultants are paid by salary for their public commitment and receive fees for treatment of private patients. Similarly, GPs are paid by capitation for medical card holders’ care and receive fees from private patients for each visit. Such mixed systems of payment create perverse incentives (Tussing and Wren 2006) and, to ensure equitable treatment, should be reformed so that providers are paid by the same method for all patients. Yet, the 2014 White Paper was mute on the design of provider payment systems, a testament perhaps to a path dependency that has evolved in the politics of Irish healthcare, with policy-makers reluctant to confront

the medical profession due to their opposition to previous reform attempts. The parliamentary committee's report recognises that changes will be required in the consultants' contract to effect the removal of private practice from public hospitals (Houses of the Oireachtas Committee on the Future of Healthcare 2017).

Although recent evidence suggests that members of the general population are in favour of universal healthcare in Ireland, with 52 per cent identifying universal healthcare as their top "ingredient for happiness" (Amarach Research 2015: 23), there remains a strong commitment to private health insurance exemplified by the over 40 per cent of the population who continued to purchase private insurance during the recent economic downturn (MillwardBrown 2016). While there has been no published polling to determine whether attitudes to UHC vary by insurance status, polling has found the majority of the insured do not want to queue for treatment (O'Regan 2014). The privately insured are disproportionately middle class as are voters for the Fine Gael party, which led opposition in the parliamentary committee to removing tax relief for PHI (MillwardBrown 2016; Gallagher and Marsh 2016). Although higher-income insured would benefit from universal primary care, to win the support of the privately insured, a universal system would need to guarantee acceptable waits for hospital care.

One of the lessons of the history of reform is that previous attempts to deliver UHC have been undermined by reform designs which contained inherent contradictions due to lack of clarity about the definition of universality. The 1991 introduction of universal eligibility for public hospital care, for instance, was undermined by the

terms of employment of public hospital consultants who might admit private fee-paying patients; and the 2014 White Paper simultaneously professed to propose a system which would deliver access according to need with payment according to ability to pay, while proposing that insurers might levy differing levels of unreimbursed excess in universal health insurance policies. Such contradictions can be interpreted as reflecting an underlying unresolved conflict in values in Irish society. This conflict arises between belief in a free market in healthcare (and implicitly healthcare as a commodity), which was defended historically by organised medicine and now extends to political defence of healthcare purchase by competing private insurers; and the opposing universalist belief in social solidarity and healthcare as a right, which motivated trade unionists in 1991 and the expression of support for the social solidarity principle in healthcare in the 2011 Programme for Government. Ambiguity persists in the Committee on the Future of Healthcare's recent discussion of UHC, which it defines as providing a wide range of health and social care services "on the basis of clinical need" while elsewhere qualifying that its vision "is a universal health system accessible to all on the basis of need, free at the point of delivery (or at the lowest possible cost)" (Houses of the Oireachtas Committee on the Future of Healthcare 2017, 58-59). However, influenced by the WHO's universal coverage cube, the parliamentary committee's proposals focus on alleviating the effects on access of patient cost-sharing, whereas the focus of the 2011-2016 Government's reforms on the financing mechanism obscured the necessity to develop policy in such other areas. The challenge remains to achieve a Government platform with a consensus definition of universality and approach to its achievement. Reaching such a consensus and avoiding internally contradictory

approaches to achieving UHC are internationally recognised as challenging policy goals (Kutzin 2012; O’Connell et al. 2014).

Further lessons from the history of reform relate to the efficacy and feasibility of reform proposals. Caution is required in translating reform designs from different cultures and systems. Only after its adoption did it become apparent that the UHI proposal based on the 2006 reforms in the Netherlands would likely contend with mounting costs and that its model of hospital competition was ill-designed for the relatively low density and dispersed Irish population. More recently, the parliamentary committee’s support for a traditional NHS model with complete separation of the public and private systems could exacerbate the dual nature of the system, where almost half the population has private health insurance. To retain a large, parallel private system would also risk attracting away staff from the public system, whereas integrating public and private delivery systems in a universal system could offer a route to addressing capacity constraints at least in part by pooling capacity.

The abandonment of the 2011 UHI proposals on cost grounds supports developing an ex ante analysis of the cost of a proposed reform and evidence of benefits for additional costs at an early stage in its design. Demonstrating the affordability of UHC following recent cutbacks is likely to be critical to the success of any proposed reform. Mechanisms to control costs should include reform of provider payment systems to favour capitation and salary and limit fee payments. If an alternative system envisages a role for private insurers, it should be outside the scope of EU

competition law giving Irish Government latitude to control insurers' margins and other costs (Wren and Connolly 2016), which requires a design according to social solidarity principles (Prosser 2010). The evolving requirements of EU law pose a particular challenge for a member country like Ireland coming late to the design of a major healthcare reform, a challenge not encountered by many European neighbour states, whose health systems predate the establishment of the EEC and the EU. For a late-starter country such as Ireland, health reform design must reconcile not only national imperatives but also the requirements of EU law.

6. Conclusions

Ireland has an inequitable healthcare system which presents significant financial barriers to accessing necessary care. This system persists despite over a century of reform attempts, culminating in the abandonment in 2015 of the proposed introduction of UHI. Shifting alliances of politicians, Churchmen and doctors defeated reform attempts in the 20th century. A historical institutionalist framework of analysis informs our understanding of how a post-colonial State with a society suspicious of government developed a weak Government and left political space for the Catholic Church to occupy. The political party system in a rural society recovering from a bitter civil war was not conducive to the development of welfare state solutions like universalism in healthcare. The successful Church intervention in support of doctors to prevent the introduction of free GP care for children in 1951 was a critical juncture which has influenced the subsequent reluctance of Irish government to confront medical opposition to reform.

Notwithstanding the development of a stronger and more developmental role for the State, the waning of Church power and the modernisation of many aspects of Irish life within the later decades of the century, the healthcare system remains an outlier within Europe. Inequities which persisted through the 20th century have in more recent decades been exacerbated by an adoption of market solutions to healthcare provision and financing. The health care system and access to it have become more fragmented, with close to half the population purchasing private health insurance to secure faster access to hospital care in both public and private hospitals. Cutbacks in public hospital provision combined with an increase in numbers of state-subsidised, private hospitals have provided motivation for this high uptake of private health insurance and thereby created a potentially large voting bloc with an interest in maintaining the status quo. Consequently, a legacy from Ireland's delayed start on the road to universal healthcare is the challenge of integrating the large private delivery system financed mainly by PHI in a universal and equitable system. Although there have been expressions of cross-party political support for the introduction of UHC, a perceived need to placate the constituency of the privately insured has already caused division in the parliamentary committee tasked with charting a path to universality.

The history of the failure of reform attempts reviewed in this paper affords some lessons for the renewed quest for a reform design. If future reforms are to be successful in delivering universal healthcare, they must start from a clear definition of UHC. Political commitment to UHC needs to be matched by a will to face down stakeholders who may seek to block reform. A break with past patterns will be

required if as in the past resisters of change include providers of care, who may oppose changes to payment methods which may reduce their income. Proposed reform design must extend beyond the 2014 proposals for financing system change, which were not necessarily synonymous with equity, efficiency or cost-effectiveness. Many other design features require consideration such as methods of provider reimbursement and systems to ensure equitable access governed by medical need.

Although unique to Ireland, the history of healthcare reform in Ireland may offer more general lessons to other countries' reform processes. Before independence and in the 1950s, developments in the UK provided the exemplar for attempted reforms; more recently the political system has looked to models of UHI, in part because they can reconcile public and private delivery of care. Recent Irish experience cautions against applying models developed in other countries, without due consideration to how such a system would operate in the host country. An approach to reform with greater likelihood of delivering early benefits is to build on the system within a country. The progressive extension of access to GP care without fees building on the existing tax-financed system is one such recent example in Ireland, supported by the recent parliamentary committee report.

While Ireland comes late to designing a universal healthcare system, other countries with ostensibly universal systems have seen dimensions of universality eroded during austerity (Thomson et al. 2009). The challenges in system reform faced by a late-starter country such as Ireland, in particular in overcoming stakeholder resistance, achieving clarity in the definition of universality and avoiding barriers to

access, may be shared by countries whose universal systems have been compromised in the period of austerity.

References

- Amarach Research. 2015. The future of Ireland. Dublin, Ireland: OMD Ireland.
- Bal, R., and T. Zuiderent-Jerak. 2011. "The practice of markets in Dutch health care: are we drinking from the same glass?" *Health Econ Policy Law* 6 (1):139-45.
- Barrington, R. 1987. *Health, Medicine and Politics in Ireland 1900-1970*. Dublin: Institute of Public Administration.
- Breen, R., D. Hannan, D. Rottman, C. Whelan. 1990. *Understanding Contemporary Ireland: State, Class and Development in the Republic of Ireland*. Dublin: Gill and MacMillan
- Brick, A., A. Nolan, J. O'Reilly, and S. Smith. 2010. Resource allocation, financing and sustainability in health care: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector. Dublin, Ireland: The Economic and Social Research Institute.
- Browne, N. 1989. *Against the Tide*. Gill and Macmillan.
- Busse, R., J. Schreyögg, and C. Gericke. 2007. Analyzing Changes in Health Financing Arrangements in High-Income Countries: A Comprehensive Framework Approach. In *Health, Nutrition and Population (HNP) Discussion Paper: The World Bank*.
- Catholic Church. 1963. Peace on earth: Encyclical letter of Pope John XXIII. London: Catholic Truth Society.
- Central Statistics Office. 2016. Ireland's System of Health Accounts, Annual Results 2014. Dublin: Central Stastics Office.
- Council of the European Union. 2006. Council conclusions on common values and principles in EU health systems. Brussels: Council of the European Union.
- Crouch, C. 1993. *Industrial Relations and European State Traditions*. Oxford; Clarendon Press
- Dail Debates. 2012. Speech by Minister of State, Roisin Shortall, in Motion of Confidence in the Minister for Health. <http://oireachtasdebates.oireachtas.ie/debates>: Houses of the Oireachtas.
- . *Role of the Committee on the Future of Healthcare* 2016. http://www.oireachtas.ie/parliament/oireachtasbusiness/committees_list/future-of-healthcare/role/.
- Daly, M. 1981. *Social and economic history of Ireland*. Dublin: The Educational Company
- Department of Health. 2014. The Path to Universal Healthcare: White Paper on Universal Health Insurance. Dublin, Ireland: Department of Health.
- . 2015. Statement by Minister Varadkar following Cabinet discussion on UHI. edited by Department of Health. Dublin, Ireland: Department of Health.
- . 2016. Progress on the first year of our three-year Statement of Strategy 2015-2017, Annual Report 2015.
- Department of the Taoiseach. 2011. Programme for Government 2011-2016. Dublin, Ireland: Department of the Taoiseach.
- . 2016. A Programme for a Partnership Government. Dublin, Ireland: Department of the Taoiseach.
- Esping-Andersen, G. 1990. *The Three Worlds of Welfare Capitalism*. Cambridge: Polity Press
- Fine Gael. 2009. FairCare: Fine Gael Proposals to reform the health service and introduce universal health insurance. Fine Gael.
- Fitzgerald, J. 2006. "Lessons from 20 Years of Cohesion", in: Mundschenk, S., M. H. Stierle, U. Stierle von Schütz, U. and I. Traistaru (eds.), *Competitiveness and Growth in Europe: Lessons and Policy Implications of the Lisbon Strategy*, Mannheim: ZEI, 66–100.

- Foot, M. 1973. *Aneurin Bevan; Volume II 1945-1960*: Davis-Poynter.
- Gallagher, M. and M. Marsh. 2016. *How Ireland voted 2016: the election that nobody won*. Palgrave MacMillan
- Garvin, T. 1999. "Democratic politics in independent Ireland", in J. Coakley and M. Gallagher (Eds) *Politics in the Republic of Ireland*. Routledge.
- Goodey, C. 2015. *Why GPs oppose free care for children under 6* <http://nagp.ie/news-media/why-gps-oppose-free-care-for-children-under-6>.
- Houses of the Oireachtas Committee on the Future of Healthcare. 2017. *Sláintecare Report*. Dublin, Ireland: Houses of the Oireachtas.
- Hsiao, W. C., A. G. Knight, S. Kappel, and N. Done. 2011. "What other states can learn from Vermont's bold experiment: embracing a single-payer health care financing system." *Health Aff (Millwood)* no. 30 (7):1232-41.
- Irish Medical Organisation. 2010. *IMO Position Paper on Universal Health Coverage*. Dublin: IMO.
- Kennedy, K., T. Giblin and D. McHugh. 1988. *The economic development of Ireland in the twentieth century*. London: Routledge
- Kringos, D., W. Boerma, Y. Bourgueil, T. Cartier, T. Dedeu, T. Hasvold, A. Hutchinson, M. Lember, M. Oleszczyk, D. Rotar Pavlic, I. Svab, P. Tedeschi, S. Wilm, A. Wilson, A. Windak, J. Van der Zee, and P. Groenewegen. 2013. "The strength of primary care in Europe: an international comparative study." *Br J Gen Pract* no. 63 (616):e742-50.
- Kutzin, J. 2012. "Anything goes on the path to universal health coverage? No." *Bulletin of the World Health Organization* 2012; 90:867-868
- Kutzin, J. 2013. Health financing for universal coverage and health system performance: concepts and implications for policy. In *Bulletin of the World Health Organization*. <http://www.who.int/bulletin/volumes/91/8/12-113985.pdf>: World Health Organization.
- Leahy, P. 2017b. "FG and FF insist recommendations on healthcare be amended." *The Irish Times*, 29/05/2017
- Loughlin, E. 2016a. "Labour minister Kathleen Lynch says Fine Gael stalled free GP care plans." *Irish Examiner*, 06/01/16
- Loughlin, L. 2016b. "Legislation by consensus will be better: Regina Doherty." *Irish Examiner*, 09/05/2016.
- Lu, J., and W. C. Hsiao. 2003. "Does Universal Health Insurance Make Health Care Unaffordable? Lessons From Taiwan." *Health Affairs* no. 22 (3):77-88.
- Lynch, F. 2014. Letter to Mr David Moloney, Assistant Secretary, Department of Public Expenditure and Reform. Released under Freedom of Information. Dublin, Ireland: Department of Health.
- Mair, P. 1999. "Party competition and the changing party system", in J. Coakley and M. Gallagher (Eds) *Politics in the Republic of Ireland*. Routledge.
- Mathauer, I., and E. Nicolle. 2011. "A global overview of health insurance administrative costs: what are the reasons for variations found?" *Health policy* no. 102 (2-3):235-46.
- Mikkers, M., and P. Ryan. 2014. "'Managed competition' for Ireland? The single versus multiple payer debate." *BMC Health Serv Res* no. 14 (1):442.
- MillwardBrown. 2016. *Health Insurance Authority - A Review of Private Health Insurance in Ireland*. <http://www.hia.ie/publication/consumer-surveys>: The Health Insurance Authority.
- O'Connell, T., K. Rasanathan, and M. Chopra (2014) "What does universal health coverage mean?" *Lancet* no. 383: 277-79
- O'Connor, N. and E. O'Regan, 2017. "Varadkar and Harris insist tax reliefs here to stay" , *Irish Independent*, 07/04/2017
- O'Connor, N. 2017. "Harris considers leasing maternity hospital land in U-turn on controversy." *Irish Independent*, 01/05/17
- O'Regan, E. 2014. "Opposition grows to plan for universal healthcare." *Irish Independent*, 07/04/2014
- O'Reilly, D., T. O'Dowd, K. J. Galway, A. W. Murphy, C. O'Neill, E. Shryane, K. Steele, G. Bury, A. Gilliland, and A. Kelly. 2007. "Consultation charges in Ireland deter a large proportion of

- patients from seeing the GP: results of a cross-sectional survey." *Eur J Gen Pract* no. 13 (4):231-6.
- Pierson, P., and T. Skocpol. 2002 "Historical Institutionalism in Contemporary Political Science", in I. Katznelson and H.V. Milner (Eds) *Political Science: State of the Discipline*. New York: W.W. Norton
- Prosser, T. 2010. "EU competition law and public services", in E. Mossialos, G. Permanand, R. Baetan and T. Hervey (Eds), *Health Systems Governance in Europe: The Role of European Union Law and Policy*. Cambridge University Press.
- Rosenau, P. V., and C. J. Lako. 2008. "An experiment with regulated competition and individual mandates for universal health care: the new Dutch health insurance system." *J Health Polit Policy Law* no. 33 (6):1031-55.
- Ruane, F. 2010. Report of the expert group on resource allocation and financing in the health sector. Dublin, Ireland: Department of Health and Children.
- Ryan, P., S. Thomas, and C. Normand. 2009. "Translating Dutch: challenges and opportunities in reforming health financing in Ireland." *Ir J Med Sci* 178 (3):245-8.
- Skocpol, T. 1979. *States and Social Revolutions : A Comparative Analysis of France, Russia and China*. Cambridge: Cambridge University Press
- Skocpol, T. 2008 "Bringing the State Back In: Retrospect and Prospect", *Scandinavian Political Studies*, 31 (2):109-124
- Smith, S., and C. Normand. 2011. "Equity in health care: the Irish perspective." *Health Economics, Policy and Law* 6:205-217.
- Taylor, M. G. 1987. *Health Insurance and Canadian Public Policy - the seven decisions that created the Canadian health insurance system and their outcomes*: The Institute of Public Administration of Canada/McGill-Queen's University Press.
- The Labour Party. 2011. Labour's Plan for Fair Health Care. The Labour Party.
- Thomas, S, P Ryan, and C Normand. 2010. Effective foundations for the financing and organisation of social health insurance in Ireland. Dublin, Ireland: The Adelaide Hospital Society.
- Thomas, S., C. Normand, and S. Smith. 2006. Social Health Insurance:Options for Ireland. The Adelaide Hospital Society.
- . 2008. Social Health Insurance: Further Options for Ireland. Dublin: The Adelaide Hospital Society.
- Thomson, S, T Foubister, and E Mossialos. 2009. Financing health care in the European Union: challenges and policy response. Denmark: World Health Organisation.
- Thomson, S , M. Jowett, P. Mladovsky, T. Evetovits, J. Figueras, A. Nolan, and C. Normand. 2012. Health System Responses to Financial Pressures in Ireland: Policy Options in an International Context. Brussels, Belgium: World Health Organisation and European Observatory on Health Systems and Policies.
- Thomson, S., R. Busse, L. Crivelli, W. van de Ven, and C. Van de Voorde. 2013. "Statutory health insurance competition in Europe: a four-country comparison." *Health policy* 109 (3):209-25.
- Tussing, A. D., and M. Wren. 2006. *How Ireland cares: The case for health care reform*. Dublin: New Island.
- Whyte, J. H. 1980. *Church and State in Modern Ireland 1923-1979*. 2nd ed: Gill and Macmillan.
- World Health Organization. 2010. The world health report: health systems financing: the path to universal coverage. World Health Organization.
- Wren, M. 2003. *Unhealthy state - anatomy of a sick society*. Dublin: New Island.
- Wren, M., and S Connolly. 2016. "Challenges in achieving universal healthcare in Ireland." *Budget Perspectives* 2017 (1). Dublin: Economic and Social Research Institute
- Wren, M., S Connolly, and N. Cunningham. 2016. "An approach to estimating the effects of financing system change on Irish healthcare expenditure." *Journal of the Statistical and Social Inquiry Society of Ireland*, XLV , 1-15.

Wren, M., S. Connolly, and N. Cunningham. 2015. An examination of the Potential Costs of Universal Health Insurance in Ireland. In *Research Series*. Dublin: Economic and Social Research Institute.