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Health Care for All in Ireland? The Consequences of Politics for Health Policy

Vivienne[Q1] Byers

The Irish health-care system is a complicated mix of public and private providers, with inequitable and unclear routes for health service users to access and navigate the system. In 2011, the Irish Government committed to significant health reform to develop a universal single-tier health system. In line with other European nations this was to be underpinned by the principle of social solidarity, with equitable access based on need rather than ability to pay. The road to this reform and its recent collapse highlights the practical implications of political and policy choices in health care, and has implications for financing and delivery, but ultimately for the delivery of national public health.

KEY WORDS: health policy, universal health care, public health, politics, health reform

Background

Ireland is a small country on the western edge of Europe with a population of about 4.6 million. It has a modern, trade-dependent economy, and has been subject to an austerity program since the recession of 2008 until very recently. Before then, Ireland had enjoyed one of the highest economic growth rates in Europe, as between 2005 and 2008 public expenditure rose by nearly 40 percent (Thomson, Jowett, & Mladovsky, 2014). Despite this growth, the Irish health-care system has remained chronically underfunded for decades, as well as plagued by increasing waiting lists due to limited access to services (Pillinger, 2012). Crucial health-care delivery issues have included lack of resources such as limited public hospital capacity, as well as failure to develop community and primary care services sufficiently. This has led to inadequate provision in areas such as mental health, chronic disease management, with limited emphasis on health promotion and preventative work (Byers, 2009; Pillinger, 2012).

The health-care system in Ireland is a complicated mix of public and private providers, with inequitable and unclear routes for service users to access and navigate the system. In 2011, the government committed to significant health policy reform to develop a universal single-tier health system underpinned by the principle of social solidarity, with equitable access based on need rather than

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ability to pay. In 2012, the concept of "universalism" was confirmed in the national health strategy outlining the government's ambition to deliver "universal primary care" and "universal hospital care" (Department of Health [DOH], 2012, pi). The World Health Report's (WHO, 2010) definition of Universal Health Care or Universal Health Coverage (UHC) is that "all people have access to services and do not suffer financial hardship paying for them." According to the WHO (2013), UHC consists of three inter-related components: (i) access to the full spectrum of quality health services based on need; (ii) financial protection from direct payment for health services when consumed; and (iii) coverage for the population. The Irish reform represented the most comprehensive overhaul of Irish health care since the establishment of the State.

The objectives of this paper are to chart the path of this reform policy from its inception to its collapse late in 2015, as well as to examine the implications for national politics, health policy, financing and delivery of health care, and ultimately for universal access to health care and the right to public health for the citizen. This is achieved through a review of the UHI reform policy documentation and the health-care context in Ireland. It also posits possible explanations through the utilization of institutional theory and an exploration of the influence of prevailing logics and governance systems, which can both facilitate and hinder such reform. These logics at societal level are created by government and embed in policies that cascade down to organizations. However, if powerful actors in the field support prevailing institutional logics, they can maintain the status quo through provision of rules of action and interpretations that guide and constrain decision makers (Thornton & Ocasio, 2008). Thus, a picture of a contested policy implementation process is drawn, and this paper looks to learn from this experience in the context of the wider European reform process.

The Policy Context

From 2008 to 2014 Ireland was in the eye of a severe recession. By 2011, Ireland's gross national product (GNP) had fallen by nearly 20 percent (Central Statistics Office [CSO], 2011, 2012). Within the European Union (EU), only Latvia, Italy, Estonia, and Greece faced recessions of greater severity (Keegan, Thomas, Normand, & Portela, 2013). Ireland's crisis was contributed to by the international financial crisis but primarily originated from poor national fiscal and public policy choices (Burke, Thomas, Barry, & Keegan, 2014). In 2010, the budget deficit reached 32.4 percent of GDP—the world's largest national deficit as a percentage of GDP (Eurostat, 2011). By late 2010, the Irish government was forced to accept a bailout with financial and governance constraints from a "troika" (comprising the [EU], International Monetary Fund [IMF], European Central Bank [ECB]) totaling €85 billion (Department of Finance [DOF], 2011). The National Economic and Social Council (NESC) in 2009 described Ireland as undergoing a number of crises; not only in banking, the economy and public finances but also socially and in terms of national status (NESC, 2009).

Ireland's health-care system has been under pressure as a result of the austerity regime. From 2009 to 2013 financing of the Health Service Executive (HSE—Ireland's national health-care delivery organization) fell by 22 percent amounting to almost €3.3 billion less in public funding (Thomas, Burke, & Barry, 2014). Staffing of public services fell by 10 percent from its peak in 2007 (Thomas et al., 2014). As a result health coverage for patients older than 70 years was reduced, prescription charges were introduced for low-income households, services were reduced, and additional out-of-pocket payments and charges were announced. These types of measures affected access to care and increased waiting lists (Karanikolos et al., 2013). This "crisis" in Irish health care led to a public outcry and the incoming government in 2011 promised a whole-scale reform of the health-care system as part of their policy platform [Q2](Programme for National Recovery, 2011). However, from 2012 to 2013 on despite the new reform agenda, Ireland continued to experience increased rationing and declining breadth and depth of coverage in health-care provision similar to Greece, Portugal, and Spain [Q3](other "bail out" countries) (McKee, Karanikolos, Belcher, & Stuckler, 2012; Mladovsky et al., 2012).

The Irish Health-Care System: The Political Context

Irish health care is predominantly tax funded with centrally administered national health service delivery through the HSE. Total health spending accounted for 8.1 percent of GDP in Ireland in 2012, less than the OECD average of 8.9 percent (OECD, 2015). Health spending as a share of GDP is much lower in Ireland than in the United States (which spent 16.9 percent of its GDP on health) and in a number of European countries including the Netherlands, France, Switzerland, and Germany (all allocating over 11 percent) (OECD, 2015). There was a significant drop in this health spend of 4.3 percent between 2009 and 2013, second only to Greece (OECD, 2015).

Ireland's Health Act of 1970 established that individuals are responsible for the costs of their own health care except in cases where this would cause that individual "undue hardship" (Byers, 2009). However, there is no express recognition of health as a human right in the Irish Constitution or legislation, as it would be seen to create an obligation upon the state to provide free health care (Irish Human Rights Commission, 2005). This is unlike many of Ireland's European neighbors whose health systems are underpinned by the principle of social solidarity. One of the critical features of Irish health care is the difficulty in balancing the relationship between public and private provision. This differs considerably from its European counterparts where a substantial amount of private health care takes place within the state-funded public hospital infrastructure. This has led to inequity in access to resources and public taxation support of private provision (Amnesty International, 2011). According to the CSO in 2014 the percentage of the population with private health insurance plans stood at about 44 percent, down from the 2008 peak of 50.9 percent [Q4](CSO, 2014). However, this private voluntary health insurance often does not fully cover services or hospital

stays and requires further contributions toward the cost of services utilized (Health Insurance Authority [HIA], 2012). Additionally, health insurance costs for consumers have risen significantly over the period 2007–12 with the average annual premium increasing by 56 percent Q5(Independent Report to the Minister for Health and Health Insurance Council, 2013).

Ireland is considered unique among EU countries in not having universal coverage for primary care. Primary care is delivered by private providers (general practitioners [GPs]) and eligibility for free care is determined via a means-tested medical card system. As of 2014, nearly 40 percent of the population, or 1.8 million people were able to access public services free of charge, as they were covered by a medical card (HSE, 2014). This means-tested coverage had increased by almost 45 percent over the decade 2000–10, and by nearly 5 percent between 2010 and 2011 due to decreases in income levels across the population (HSE, 2012). A study by the Irish Pharmacy Union (IPU, 2015) noted that there were significant differences between Medical Cardholders and non-cardholders in visiting a GP or getting a prescription. Thus, many working-age residents in the middle of the Irish income spectrum who are neither old nor poor enough to be eligible for the free Medical/GP Visit Card scheme, also find themselves unable to afford health insurance, and are disadvantaged in the current Irish health-care system.

As a result, Ireland has a complex system of health care, in which people on lower middle or middle incomes struggle to access needed care, while people with private health insurance get preferential access to care in public hospitals or to higher-quality treatment in the separate private hospital sector, albeit often with additional co-payments (Bidgood, 2013). From a primary care perspective there are limited incentives to access preventative care for over 60 percent of the population. This complex mix of care has resulted in a "historic" rather than needs based resource allocation system, cost over runs, inequitable access; public care waiting lists and a poorly developed primary-care system (Pillinger, 2012).

The Irish Health-Care System: The Ethics of Rationing

The dilemma for national health-care systems in times of austerity is the fairness of health-care distribution across the population. Ireland's health-care system during the recession experienced severe budget cuts, a growing population, and increased inequitable access. According to the Irish Health Information and Quality Authority (HIQA, 2013), the recession led to a form of rationing by delay in the public health-care system, as demand for care could not be satisfied from within available resources, resulting in waiting lists for specialist assessment, as well as for treatments and procedures. Rationing of care can be described as denying a potentially beneficial treatment to a patient on the grounds of scarcity (Scheunemann & White, 2011). Such rationing according to Teutsch and Rechel (2012) can affect three dimensions of coverage: (i) the share of the population covered (eligibility); (ii) the services covered; and (iii) the extent to which these services are covered (scope). This raises questions about fairness in

the equitable distribution of resources and what ethical principles should guide such distribution.

It can be difficult for stakeholders in health-care systems to agree the principles that should guide rationing. Some countries attempt to depoliticize decisions regarding rationing by using health technology assessments through dedicated agencies (Teutsch & Rechel, 2012). In the Irish context, HIQA was established to drive improvement in health services and to monitor the safety, and quality of these services as an independent authority. They have compiled guidance documents in order to ensure that ethical principles are considered in health technology assessment (HIQA, 2012, 2013). HIQA (2013) notes that in the Irish context, allocation needs to take into account a range of ethical considerations including fairness, respect for autonomy, responding to individual need, and benefiting the wider population. They cite Butler (1999) who recommends that the structure and organization of health care should not be left to chance or interest, but must be planned and implemented in ways that make explicit the principle of justice. However, the ethics of fair health-care distribution had not been addressed as such at a national policy level; rather the focus of the political and policy discourse was on the optimum use of available resources, through cutting waste and increasing spending efficiency (Briggs, 2013).

The Institute of Medicine's Committee on the Consequences of Uninsurance (2004) identified the five key principles for guiding fair and just coverage. However, they cited the first principle as the fundamental one; namely that health-care coverage should be universal. The others were not ranked but included that coverage should be continuous, affordable, and funded so as to be sustainable for society and enhance health and well-being through promoting access to care. Thus, the critical political question articulated by the new Irish government in 2011 was how to implement and operate health services in order to improve access and improve population health. The Department of Health (DOH, 2014) recognized that the two-tier system was undermining the development of a modern, responsive, and sustainable health service. It is within this context that the government sought to introduce large scale reform espousing the principle of universal access through the vehicle of UHI in Irish health care.

A Policy Window Opens

The Irish Government (2011–16) identified in their Programme for Government the aim to introduce universal health insurance (UHI), and thus, UHC access during the life time of their term in office. In November 2012, they published their strategy document; "*Future Health: A Strategic Framework for Reform of the Health Service 2012–2015*." Their vision was that of a single-tier health service which promoted health and well-being to be achieved through UHI (DOH, 2013, p. 10).

The White Paper (DOH, 2014) outlined how the insurance component of the reform would operate in mandating Irish residents to take out private health insurance, which would cover a standard basket of services (including primary

and acute care). The composition of this basket was never fully determined and remained unspecified in documentation (Wren, Connolly, & Cunningham, 2015). The outline plan was that those on low incomes would have their premiums paid for by the State. For those already holding private insurance they would continue to pay premiums and access a wider range of services (including primary care) but they would not be fast tracked in access to health services. Purchasing of health-care services was to be devolved to insurers through commissioning care for their members from primary care providers, independent not-for-profit hospital trusts, and private hospitals. In doing this, they would have a duty to use their purchasing role to ensure the provision of quality, continuous care across settings (DOH, 2013, 2014). The White Paper also proposed that there would be reserve powers to cap insurer profits, expenses, cost of capital, and claims. The aim was that the UHI system would create incentives for managed competition between providers and insurers that would encourage the most efficient use of health care (Society of Actuaries in Ireland [SAI], 2014). Deploying an institutional perspective can reveal the use of such reforms as legitimating devices, appearing egalitarian and in the best public interest such as "universal health care," yet underpinning the policy vision is a set of proposed governance structures with a strong market and managerial logic (Scott, Martin, Peter, & Carol, 2000). However, according to the DOH (2012) this represented the most comprehensive reform of Irish health care since the establishment of the State. If Ireland had successfully completed this transition, it would have been a significant event in European health policy, as it would have represented an example of a democracy with a long-established tax-financed centralized health-care system subsequently decentralizing and switching over to a universal insurance model (Bidgood, 2013).

There are a number of perspectives that can be taken in looking at the policy window in Irish health care, this reform and its true intent. For medical professionals, the policy was described as an insurance-based model that was "*mis-sold as a commitment to equitable healthcare*" (Irish Medical Organisation [IMO], 2015). For insurers, there were concerns about the lack of consideration of the regulatory capital consequences, as well as issues managing the cost constraints and the capping of insurer profits (SAI, 2014). The population never fully engaged with the import of "universal health insurance" as its introduction coincided with wide cuts to eligibility and access. For those already carrying private insurance they would have continued to pay similar, or larger premiums, but would no longer be fast tracked in accessing services. For those with medical cards their premiums would have been paid; however, those without access to free health care and who had not been able to afford private insurance to date, would have had to pay health insurance as well as taxes.

The changes envisioned were sweeping, offering opportunities, but also challenges to the system, providers, and the patients themselves. What is clear is that they were introduced in the context of severe health-care budgetary cuts. However, it is unclear how such a change could have come about in the time line outlined and with the resources available. The health reform proposals received

much public criticism; many arguing for improvements to be made to the present taxation system to make it more equitable, others arguing for a "social" health insurance system (Turner, 2014). There was widespread scepticism regarding the ability to move to and operate a managed competition model successfully (SAI, 2014; Turner, 2014).

The Irish approach was influenced by the Dutch experience of market-oriented reform. The intention of the Dutch reform since 2006, has been to bring about a system of regulated competition in health care by introducing competition, enhancing consumer choice, as well as upholding fundamental values in health care, such as universal access (Maarse, 2011, Maarse et al., 2016). Okma, Marmor, and Oberlander (2011) note that the reforms have fallen far short of expectations as a result of lack of transparency, weakened consumer trust in insurers, and lack of cost control. However, there have been improvements in primary care delivery. According to Mikkers and Ryan (2014: p3), managed competition requires a long transition period and sufficient preconditions such as risk equalization, market regulation, and transparency which need to be in place for effective performance. This is where Ireland failed to prepare and the Dutch succeeded. Yet, the Dutch reform is far from successful, as the system remains costly (Van Ginneken, 2015).

Implications for Public Health

However, reform was needed in the Irish system. In 2014, 3.7 percent of the Irish population aged 16 and over, reported unmet need for medical care (Eurostat, 2016). Although this is an average across the EU-28 (EU States), the percentage doubled from the 2004 figure (1.8 percent). This growing unmet need for medical care is a result of the population having difficulty accessing treatment and has real consequences for the health status of the population (D. Zavras, Zavras, Kyriopoulos, & Kyriopoulos, 2016).

Apart from the sequelae of decades of under investment in the health system itself, what was the impact of austerity, high taxation, and cuts in public health investment in Ireland during this time? Many Irish health statistics remained positive. In 2013, life expectancy in Ireland stood at 81.1 years, just above the OECD (2015) average (80.5). The health effects of austerity are unclear so far and it may be some decades before a clearer picture emerges in this regard. However, rates of poverty and deprivation have increased significantly in Ireland since the beginning of the crisis. A calculation of the impact of the crisis between 2008 and 2012 on the median income of households with children suggests that Irish families have lost the equivalent of 10 years of income progress (UNICEF Office of Research, 2014). Statistics in 2010 indicated a significant differential in life expectancy between those who lived in poorer versus wealthier areas of around 4.5 years less for men and nearly 3 years less for women (CSO, 2010). The child poverty rate rose by over 10 percent to 28.6 percent over the period 2008–12 (UNICEF Office of Research, 2014). Given this causal relationship between poverty and ill health, it is inevitable that increases in poverty during this time

will impact on population health, although the impact is not yet explicit in most health statistics (Nolan, Barry, Burke, & Thomas, 2014).

In contrast to the availability of information on the economy, the absence of up-to-date detailed morbidity and mortality data have made the immediate effects of the crisis on health difficult to analyze. This has left much policy and research attention focused on economic aspects such as the resilience of the "system" itself to deliver (Nolan et al., 2014; Thomas et al., 2013). Remarkably little research has focused on the health consequences of the crisis and much of what has been done has been undertaken by patient and other non-governmental organizations and individual researchers (Karanikolos et al., 2013). Countries burdened by austerity policies tend to have higher rates of poor health, particularly in the unemployed, increased prevalence of mental health problems, suicide, and self-harm, as well as increased incidence of infectious diseases, such as HIV (Brand, Rosenkötter, Clemens, & Michelsen, 2013; Legido-Quigley et al., 2013). In Ireland, the health issues reported, include those of obesity, diabetes, chronic disease, suicide, self-harm, and mental health issues. The WHO Modelling Obesity Project has highlighted the seriousness of obesity for many EU countries, but significantly in Ireland where projections suggest that almost all Irish adults will be overweight by 2030 (Breda, Webber, & Kirby, 2015). Other worrying health indicators include a continuing increase in suicide particularly among younger people, with Ireland having the highest rate of suicide across Europe for young females (under 25) and the second highest rate of suicide in young males (Cannon, Coughlan, Clarke, Harley, & Kelleher, 2013; MacKay & Vincenten, 2014). A number of other isolated statistics show the effect of austerity on health and well-being; under-resourcing of specialized diabetes screening resulted in a 12 percent increase in lower limb amputations between 2013 and 2014 (O'Regan, 2015); growing waiting lists for the provision of therapy services have led to significant delays (e.g., up to three years) in treatment and access (Laois Offaly Families for Autism [LOFFA], 2015).

Conclusions and Policy Implications

The ultimate aim of Irish and International UHC policy is to improve population health (Moreno-Serra & Smith, 2012). In 2011, the Irish government committed to significant health policy reform to develop a universal single-tier health system. Ireland is unique in Europe in not having a universal health system; rather it presents a system which effectively omits key population groups through gaps in cost coverage, particularly for access to primary care (Thomson et al., 2014:42).

The program to deliver UHC by the means of UHI has now been effectively abandoned (Varadkar, 2015). Its failure suggests that the implementation of UHC did not move from one stage to another, instead its progress was slowed by non-linear societal logics that were in constant conflict. Ostensibly, the high costs to both the citizen and government have been blamed for this failure with the Government's proposals estimated to increase

overall health-care spending by between 3.5 and 11 percent (Wren et al., 2015). Yet such financial information would or should have been available, even anecdotally, at the outset of the policy development and its implementation. So why did government follow a path that was not financially viable? A number of explanations can be posited. Drawing from the institutional theory perspective, the first explanation is that the thrust of the policy illustrated mimetic isomorphism in which the introduction of a "quasi" market with commissioning insurers and competing providers was influenced by earlier reforms in the Netherlands. Similar patterns of organization, market-driven reforms, and competition have been seen across Western OECD health-care systems (Byers, 2016). The IMO (2015) described the reform as one that at first appeared inclusive, but in reality was a business proposition from the outset. Thus, its failure could be possibly attributed to a return to the path dependence of institutional arrangements and policies in the Irish health system with actors, including health professionals, their associations, and latterly the health insurance companies, mobilizing to halt UHI implementation (e.g., Irish College of General Practitioners [ICGP], 2014; SAI, 2014).

However, a second explanation is that the two key political parties that formed a government in 2011 following their election, did so using UHC policy as a key plank in their election campaign and as a potent source of votes. They both subsequently entered into a majority coalition government on the basis of delivering UHC through UHI and then proceeded to implement austerity cuts, slow the UHI implementation process, implement contradictory policies (such as cuts to eligibility). Eventually by the end of 2015 they had dismantled the very plan they had promulgated. Though it has not been unusual in Irish health care for rhetoric and reality to be misaligned, this particular reform illustrates an unwillingness even to "play the game" by introducing a symbolic major health reform without specifying clear objectives and a tangible implementation plan (Burke, Normand, Barry, & Thomas, 2016).

This paper serves as an interesting example for other national health systems in the triumph of politics (as in how decision makers influence or are influenced) and political short-termism, over public policy (an overt statement of government values). The reduction of "health policy" to its content can divert attention from, and render invisible the political nature of the policy process (Bambra, Fox, & Scott-Samuel, 2005). Following the recent Irish national election, a draft of the new Programme for Partnership Government (Government of Ireland, 2016) identifies a number of priorities in health care that have little overall coherence in terms of a statement of values or policy direction. It's only in the final section, that it is emphasized that an all-party committee will be formed to develop a 10-year plan which will be delivered through a new funding model and be key to the *"sustainability of Universal Healthcare."* As commentators in the media have pointed put, Ireland's new government now faces the challenge in how to *"devise policies that serve the common good, rather than being dictated to by the most powerful interest groups in society"* (Collins, 2016). Ultimately, this has implications for the electorate who vote for political parties on the basis of core values (policy) and then receive a

governmental program that lacks any coherence (politics). Whither the ambition of affordable access for all?

If Ireland had successfully completed the transition to UHC, it would have represented an example of a developed democracy with a long-established tax-financed health-care system subsequently decentralizing and switching to an insurance model. This reform though espousing the principle of universal access was actually premised on a competitive market based model rather than a centralized public monopoly structure as in the United Kingdom (Bidgood, 2013). This paper has a number of limitations. The first is that it is a review of publications and data chosen by the author, and thus, the analysis could be seen to reflect a bias in focus. A second limitation is that the paper is written at a significant transition point in Irish health policy and it can be seen by some as too early to determine the consequences of policy decisions as the effects have yet to emerge. However, this paper's key contribution is to highlight the inconsistency between stated policy aims and real political intentions, and may well serve as a point of reference for further discussion and research. The lessons from the failure of this policy have implications for health reform.

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Notes

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