INTRODUCTION

The Irish health care system is unusual within Europe in not providing universal, equitable access to either primary or acute hospital care. There are two main categories of entitlement to public health services. Those in Category I (medical card holders) are entitled to free public health services but pay a copayment for prescription items, and those in Category II are entitled to subsidized public hospital services and prescription medicines, but pay the full cost of general practitioner (GP) and other primary care services. In November 2005, the GP visit card was introduced; GP visit card holders are entitled to free GP visits but otherwise have the same entitlements as Category II individuals. Eligibility for a medical/GP visit card is assessed primarily on the basis of an income means test, with the threshold for GP visit cards about 50% higher than for the medical card. However, in the summer of 2015, a GP visit card was extended to all children under the age of six, as well as to people aged 70 and over. In 2016, 36% of the population had a medical card and 10% had a GP visit card.

Approximately 43% of the population (mainly higher income groups) are covered by private health insurance (PHI), which is mainly used to access private hospital care, supplied in both public and private hospitals. There is a growing body of evidence that some people are experiencing difficulties in accessing health care due to cost, and long waits for public hospital care (in particular for those without private insurance) are a barrier to accessing timely hospital-based services.

This inequitable and complex mixed public–private system has persisted in Ireland despite much criticism and repeated reform attempts over the past 100 years. However, there is increasing interest in and desire for a fundamental reform of the Irish health care system, including the introduction of universal health care. Though there is some ambiguity about the meaning of universal health care within Ireland and beyond, one commonly used definition relates...
universal health care to a health system in which patients are treated based on need rather than ability to pay. The aim of this article is to examine the prospects for reforming the Irish health care system by introducing universal health care. This was done by reviewing the national and international literature on health system reform in order to identify factors that may help or hinder reform in the Irish context. A number of potential factors were identified; in this article, the focus is on three factors that appear most relevant to the Irish context (the definition of universality, the presence of vested interest groups, and exploiting windows of opportunity). The next section will briefly review recent attempts to reform the Irish health care system. The following section will examine prospects for reform based on the three aforementioned factors, and the final section will make recommendations about how best to achieve reform in the Irish context.

REFORMING THE IRISH HEALTH CARE SYSTEM

Though many European countries moved toward universal health care in the period after World War II, the powerful positions of the Catholic Church and the medical profession in Ireland were instrumental in impeding reform through the first half of the 20th century. The Catholic Church, fearful of socialism or reforms that would dilute Catholic control of health care institutions and sexual morality, allied with the medical profession who feared state employment and loss of private fee income, opposed reforms that would have increased state provision of health care. This lack of significant reform, coupled with a history of underfunding, has resulted in a health care system that requires structural reform as well as more investment in order to improve access to health care services.

Recognizing the need to reform the Irish health care system, in 2011 a newly elected government (including Fine Gael and the Labour Party) committed to a universal health care 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.” The government 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 universal health insurance (UHI). This was the first time in the history of the Irish state that there was a political commitment to the introduction of universal health care in Ireland. Although in 2015 the reform proposal was abandoned on cost grounds, the idea of universal health care was now firmly on the political agenda.

In local and national elections in 2014 and 2016, the health care system was deemed the number one concern for citizens, consequently, in the run-up to the 2016 general election, three out of the four main parties (Fine Gael, Sinn Fein, and Labour) committed to universal health care. Following the election, because no party had a majority, a coalition government was formed between Fine Gael and independent parliamentarians. Shortly after the formation of the new coalition government, a former junior health minister (Roisin Shortall), now no longer in government, introduced a proposal to establish an all-party committee with a remit of agreeing on a ten-year strategy for health reform. Subsequently, an all-party parliamentary committee was established with the aim of achieving a long-term vision for health care and the direction of health policy in Ireland.

The committee’s final report (Sláintecare), published in May 2017, noted the need to move toward equitable access to a high-quality, universal, single-tier health system for Ireland. The report recommended the introduction of universal GP and primary care, reducing or removing out-of-pocket fees, and substantially increasing public health care expenditure and capacity in a tax-funded system. It further recommended that the two-tier system in public hospitals should be addressed by eliminating the provision of private care in public hospitals.

Despite the cross-party membership of the committee, the adoption of these recommendations by government would not appear to be a foregone conclusion and progress in their implementation has been limited. In August 2018, some 15 months after the publication of the Sláintecare report, the government produced a Sláintecare Implementation Strategy. The strategy set out the governance and accountability arrangements that the government has set in place in order to implement the plan, including the establishment of the Sláintecare Programme Office and an Advisory Council. Though some key appointments have been made, the strategy for the three years to 2021 does not contain concrete commitments or measures to expand eligibility to improve access as recommended in Sláintecare. The Irish health care system therefore stands at a crossroads and it remains to be seen whether, when, and to what extent universal health care will be delivered.

UNIVERSAL HEALTH CARE IN IRELAND—WHAT ARE THE PROSPECTS FOR REFORM?

Though political support is an essential starting point for the introduction of universal health care, there are a number of other factors that can contribute to or impede its development within a particular country. These include the presence and strength of left power, social movements and vested interest groups, economic resources, and windows of opportunity. In the Irish context, the presence of potential vested interest
groups and exploiting a particular window of opportunity appear to be the most relevant factors and will be explored in the following sections. Given that there appears to be some ambiguity in the definition of universality being employed in Ireland, this factor will also be examined.

**Definition of Universality**

Though the term universality in health care is commonly used, it is somewhat unclear what is actually meant by the term. Within the Sláintecare document, it is unclear whether its definition of universality implies access to care free at the point of use.\(^{13}\) Though the report initially adheres to the principle that “care should be provided free at point of delivery based entirely on clinical need,”\(^{13}\) (p43) the report later adopts a definition of universality that does not encompass care free at the point of delivery but rather has the objective that the “cost of using services does not put people at risk of financial harm.”\(^{13}\) (p57) Separately, it is stated that “the vision of the Committee 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).”\(^{13}\) (p58) Given that the existing Irish system bases eligibility for free care on means testing, this ambiguity could on some readings imply no departure from the current situation.

Further contradiction in the report includes a listing of many services with the recommendation that they “should come under the remit of universal health care,” (p58) while separately envisaging that charges will remain for services in the list, such as access to public hospital emergency departments, prescribed medications, long-term care, and dental services.

Although the report recommends universal GP and primary care and explicitly references and costs progressive extension of entitlement to free GP care, it is not clear whether the committee envisaged that charges should remain for access to other primary and social care services.

It is possible that the ambiguities in the Sláintecare report mask divergences in the committee members’ views of how universality should be defined and implemented. In some instances, these divergences have become explicit. For example, a proposal to remove tax subsidies for private health insurance was opposed by government ministers and voted down in the committee.\(^{18}\) Hence, despite a seeming political commitment in Ireland, in principle, to universality, it is unclear whether there is a genuine consensus on its definition or what it would entail in practice.

Furthermore, it remains to be seen whether there is a concurrent commitment to funding universal health care. This is especially relevant in the Irish context given that a previous attempt to introduce universal health care financed through UHI was rejected on cost grounds.\(^{11}\) The Sláintecare report estimated the cost of reforming the health care system, including the introduction of universal health care, to add in the region of 2.8 billion euros to current public health care expenditure per annum at the end of a ten-year period, with an additional one-off payment of three billion euros required to support investment across the health system.\(^{13}\) Though universal health care has been successfully introduced in a number of countries with lesser economic resources than Ireland (such as Thailand and Rwanda), the existing relatively high expenditure on health care in Ireland as well as increasing demands from a growing and aging population may act as a barrier to raising additional funds necessary for a universal system. Although much of the additional public funding would replace private funding and thereby not add to total health care expenditure, this point is seldom made in debate on the topic.

**Vested Interests**

The existence of powerful vested interests can be sufficient to block progress toward universal health care.\(^{17}\) For example, in the Irish context, opposition to universality may arise from attachment to a private market in health care\(^{1}\) from various groups, including those with PHI, medical personnel working within the private system, and private insurance companies.

Currently, those with PHI can bypass aspects of the public hospital system by attending private hospitals and clinics and therefore may be less willing to contribute additional tax revenues for a service that they perceive they will not use. Recent analysis found that though 87% of people were in favor of the introduction of universal health care in Ireland,\(^{19}\) those who currently pay out of pocket for GP and other primary care were less in favor than those who currently receive such services free at the point of use, which may be associated with higher prevalence of private insurance among those who currently pay out of pocket. Experience from other countries including Brazil\(^{20}\) and China,\(^{2}\) for example, have shown the importance of public support in driving significant health care reform. In order to ensure buy-in from the public in Ireland (especially among those with PHI) it will be necessary to promise and deliver a high-quality public health system that provides appropriate care in a timely manner so that all individuals are willing to contribute to and use the public system.

Under the current two-tier system, consultants are paid by salary for their public work and receive fees for their treatment of private patients, and GPs are paid by capitation for public patients and receive fee-for-service from their private patients. Under a universal system, it is envisaged that there
could be a change in the methods of reimbursement, with a move away from fee-for-service toward pooled budgets (to better support integrated and universal care), which may have negative implications for health professionals’ income. Therefore, careful negotiation will be required with groups operating within the current system to ensure that they do not impede reform. Recent experience in the Irish system has shown how negotiations between medical professionals and government were successful in introducing reform. In 2015, more than 92% of GPs signed up to a contract to provide free GP visits for children aged under six despite the proposal initially being opposed by some GP organizations. Agreement came at a price, however, with GPs securing an increase in funding for the provision of services to new and existing public patients.

Window of Opportunity

Though the aforementioned factors could potentially inhibit the introduction of universal health care in Ireland, a particular set of circumstances within the Irish context may make it possible to overcome these issues. Previous work has described how the convergence of multiple factors has contributed to establishing a particular window of opportunity that allows a policy entrepreneur to push a policy proposal that addresses a particular problem. Capitalizing on particular windows of opportunity has been instrumental in introducing universal health care in a number of countries. For example, universal health coverage became a national priority following a period of financial crisis in Thailand and Turkey and during post–World War II reconstruction efforts in France and Japan, and in China significant progress toward universal health care was achieved following the SARS outbreak. In these countries, periods of major upheaval created opportunities to break through interest group resistance to reforms and allowed innovative approaches to be advanced and adopted. In the Irish context, the combined factors of public and political dissatisfaction with the Irish health system and the formation of a government without majority support in parliament after the 2016 election (which facilitated smaller political parties to develop policy) created an opportunity for the development of a major cross-party health system reform plan to deliver universal health care.

Ireland is currently recovering from a severe economic downturn and subsequent austerity measures that resulted in significant cuts to the Irish health budget. Ireland is also coming relatively late to population aging and has a rapidly growing population, which has exacerbated the effects of failure to invest in services during the austerity period. Though PHI shielded some individuals from particular aspects of the austerity measures, a decline in the number of people purchasing insurance and a recognition that PHI does not bestow any advantage in achieving admission to a public hospital as a nonelective inpatient (services generally not supplied by private hospitals) has highlighted the need for an effective public health care system. This dissatisfaction with the current system together with the lack of a majority in the last general election facilitated an opening for a parliamentarian from a newly established, small party, the Social Democrats, to become a policy entrepreneur and take the lead in achieving agreement on and subsequently chairing the committee on the future of health care. It remains to be seen whether this particular window of opportunity will be sufficient to overcome other obstacles to universal health care.

DISCUSSION

For the first time in the history of the Irish state, universal health care is now firmly on the political agenda. However, 18 months after the publication of the historic Sláintecare report, little progress has been made in reforming the Irish health care system. Though the government has (belatedly) published an implementation plan and established various offices and councils, it remains to be seen whether universal health care will be introduced in Ireland. Based on the experience in other countries, a number of steps are now required by the government to capitalize on the political support for universal health care; these include clearly defining what universal health care means in the Irish context as well as identifying and addressing vested interest groups.

Clarity is required on the definition and interpretation of universal health care in the Irish context. Only then will it be possible, firstly, to determine whether there is political consensus on achieving universal health care and, secondly, to appropriately cost the proposals and identify whether there is a commitment to funding universal health care.

Transitioning from existing institutions and systems of financing, delivery, and access will be complex and require Ireland-specific approaches, given the unique Irish starting point. Caution is required in translating reform designs from different cultures and systems. For example, the 2011 UHI proposal for Ireland was based on the 2006 reforms in The Netherlands and only after an extended period of time and analysis did it become apparent that the model of hospital competition applied in The Netherlands may not be suitable for the relatively low-density and dispersed Irish population. Once the definitive Irish pathway to universal health care is decided, the overall societal cost and other implications of the proposed reforms can be quantified.

Further, there is a requirement for the government to identify and develop a strategy to prevent reforms being impeded by potential vested interest groups, especially those associated
with the private provision of health care. Strategic management of interest group pressures is essential to enable reforms to be successful.\textsuperscript{25} In Turkey, for example, in moving toward universal health coverage, reformers first developed a roadmap for reform that began with the identification of interest groups likely to be opposed to it. With an understanding of their motivations for opposition, the government then developed strategies to manage the opposition.\textsuperscript{30}

Such an approach should be adopted in the Irish context. However, care is required when negotiating with potential interest groups, because decisions made in this process may have longer term negative consequences.\textsuperscript{25} In Ghana, for example, the decision to use fee-for-service financing led to problems with financial sustainability of health care reforms.\textsuperscript{31}

To translate the political support for universal health care into concrete achievements that advance universality in the Irish system, an important first step is to clarify the meaning of universal health care for Ireland, which requires developing a consensus about the ultimate objectives of the reform and the measures required to implement it. This should be accompanied by a strategy to identify and manage vested interest groups who might oppose reform.

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