

Ireland's health care system and the crisis: a case study in the struggle for a capable welfare state

*O sistema de saúde irlandês e a crise:
um estudo de caso na luta pela capacidade do Estado Social*

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Abstract

Ireland's health care system is a weak Beveridgean system with no entitlement to free care and substantial acute waiting lists. Just under half the population has voluntary private health insurance and there is a two-tier access to acute care with dual practice consultants. Ireland experienced a multifaceted and severe economic crisis from 2008. From late 2010 until late 2013, the government was forced into a Troika bailout of €85 billion. The health sector was given a fairly free hand in the initial Memorandum of Understanding although there was substantial dialogue between the Irish government and the Troika on overspending, competition, the safety net system and high pharmaceutical costs. Yet, in reality, Ireland imposed its own austerity package cutting on health resources and shifting costs onto families and private households. This caused a negative impact on the financial protection of households, acute hospital waiting lists and the health status of the population, albeit alongside some efficiencies. Nevertheless, there is hope for a better health care system with the cross-party development of the Sláintecare Plan to bring Universal Health care over a ten year period through expanded entitlements and system overhaul. Despite opposition from vested interests this is slowly being implemented.

Key Words:

Austerity, efficiency, cost-shifting, universal healthcare, health policy, Ireland.

Resumo

O sistema de saúde irlandês pode ser caracterizado como um sistema Beveridgeano fraco, sem direito a cuidados de saúde gratuitos e com substanciais listas de espera para casos agudos. Um pouco menos de metade da população tem, de forma voluntária, um seguro de saúde privado havendo dois níveis de acesso para cidadãos com casos agudos a médicos a exercer em vários setores. A Irlanda sofreu uma grave crise económica multifacetada a partir de 2008. O governo foi forçado a um resgate da Troika de €85 mil milhões no final de 2010 do qual saiu no final de 2013. O Memorando de Entendimento inicial tinha uma grande margem de manobra para o setor da saúde, embora tenha havido muito diálogo entre o governo irlandês e a Troika sobre o excesso de despesa, competitividade, sistemas de segurança e os elevados custos com medicamentos. No entanto, na realidade, a Irlanda impôs o seu próprio programa de austeridade, cortando recursos na saúde e mudando os custos para o lado das famílias. Isto teve consequências negativas na proteção social das famílias, agravamento das listas de espera hospitalares e, de uma forma geral, para o estado de saúde da população, embora se verificasse paralelamente alguma melhoria de eficiência. Ainda assim, há esperança num melhor sistema de saúde com o desenvolvimento interpartidário do Plano Sláintecare que tem como objetivo implementar num prazo de dez anos um sistema de saúde universal, através de uma revisão do sistema e do alargamento dos direitos. Apesar da oposição dos poderes instituídos, pouco a pouco, esta reforma tem vindo a ser implementada.

Palavras Chave:

Austeridade, eficiência, transferência de custos, cuidados de saúde universais, política de saúde, Irlanda.

Very brief characterisation of the national health care system

Ireland's health care system may be characterised as a weak Beveridgean system where the majority of funding comes from taxes (around 70%[1]) but there is no associated entitlement to free care. Furthermore, Ireland has only relatively recently adopted any commitment to Universal Health care in 2011[2]. The Irish system is highly unusual in Europe in that most patients pay unsubsidised market prices to access a general practitioner (GP). In addition, Irish patients typically face lengthy waiting time and lists to access acute elective care and even some components of primary and social care. Consequently, according to Eurostat, in 2014 Ireland had the second highest rate of unmet need for health care in the European Union (EU) (at 40.6%) due to cost, distance or waiting lists (compared to an EU average of 26.5%). Costs were the most frequently mentioned factor (35.9%) and this was the highest proportion for any EU country¹.

Thirty percent of overall funding coming from private sources is a mixture of out-of-pocket payments (OOP) and private voluntary health insurance [1]. Interestingly, Ireland has one of the highest shares of, and coverage of population by, voluntary health insurance in Europe, along with France and Slovenia. Nevertheless, unlike the latter two countries voluntary health insurance in Ireland provides much less financial protection from OOP and there are key concerns about its affordability [3]. Nevertheless, those with voluntary health insurance, around 44% of the population, have historically accessed acute elective services much faster. This has created a two-tier system which government actively subsidises through taxation breaks and historic undercharging of hospital beds for private patients.

Most acute care, around 85% in 2015, is provided by publicly funded hospital sector (which includes state hospitals and voluntary not-for-profit hospitals)[4] with typical overcrowding by bed occupation rate. Nevertheless, there has been a steadily growing for-profit private hospital sector with unutilised capacity. Private care is also delivered in public hospitals. Most hospital consultants work dual practice and there have been recent media reports on consultants with long waiting lists failing to meet their public sector commitments and preferentially treating private patients. Long waiting lists for acute care have meant that emergency department (ED) attendance has been a key route to get into hospital (as will be seen.) All GPs are private entrepreneurs but are contracted by the state to provide services, particularly for those below

a certain income level who get a "medical card" which entitles them to largely free GP care², low cost prescription drugs and free hospital care. A growing proportion of the population, by age and means, are eligible for a GP visit card, where the state pays GPs to provide care free of charge). This is significantly cheaper than providing them with medical cards[5]. Other primary and community care is under-resourced, understaffed and very patchy across the country leading to large geographic disparities.

Size and duration of the economic crisis

According to Keegan et al [6], Ireland experienced the third most severe recession in the EU in the initial aftermath of the economic crisis, second only to Latvia and Estonia. Nevertheless, Ireland also experienced one of the longest recession periods, with six austerity budgets, emerging from recession in 2014[7]. Several factors contributed to this.

As a small open economy, Ireland was particularly sensitive to global economic trends. Secondly, Ireland's tax policy focussing on indirect taxes proved disastrous in a recession for government revenues[8]. Moreover, years of access to cheap credit without proper government oversight led to a property market bubble. This in turn contributed to a banking collapse and when the state introduced the bank guarantee system it tied banking debt to sovereign debt causing huge problems for the state's solvency[9]. This bank guarantee was heavily criticised subsequently and was a result of direct lobbying by the Irish banks[10]. Such events also caused a reputational crisis with outside lenders leading to a huge hike in rates for state borrowing. Consequently, in November 2010[10] the government was forced to accept a bailout from the EU, International Monetary Fund (IMF) and European Central Bank (ECB) of €85 billion.

This Programme of Financial Support was to cover the 2010-2013 period. It specified a diverse programme of fiscal measures, financial sector reforms and structural reforms for each quarter between the beginning of 2011 and the end of 2013. Precise and radical targets were set for reduction in public spending, increase in

1 - http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_un1e&lang=en

2 - Some GPs do charge administrative fees to GMS patients (for warfarin monitoring, social welfare forms, sick notes, etc.)



Table 1 - The evolving dialogue around health sector conditionalities and reforms between the IMF and Irish Government (December 2010 to November 2013)

Covering the original Memorandum of Understanding, nine updates and related statements (in **bold**) with associated Letters of Intent from the Irish State (in *italics*).

Financing
<i>"Improve the charging regime for private patients in public hospitals and increase collection of charges, to fully account for costs"(Letter of Intent, November 2012)</i>
<i>"We are in the process of implementing the remaining key pieces of the budget package: legislating to effect higher charging for private patients in public hospitals. . ."(Letter of Intent March 2013, Point 14)</i>
60. The authorities are committed to the introduction of a prospective case-based payment system for public hospitals, in line with a principle of case based cost recovery for use of public hospitals by public and private patients. This will be implemented on a phased basis beginning with a shadow phase by end-October 2013. (9th update MoU June 2013)
Pricing and reimbursement of pharmaceuticals
<i>"we have recently negotiated a significant multi-year reduction in the price of pharmaceuticals"(Letter of Intent, November 2012)</i>
<i>"we are seeking further durable savings, including through consideration of a range of structural reforms to further reduce drug costs, including by lowering the price of generic drugs and increasing the share of generics in prescriptions, dispensing and usage"(Letter of Intent, November 2012)</i>
"The authorities will conduct a study to compare the cost of drugs, prescription practices and the usage of generics in Ireland with comparable EU jurisdictions"(Point 38.) (7th update MoU January 2013 and repeated in 8th and 9th update)
<i>"We are in the process of implementing the remaining key pieces of the budget package: . . . to mandate greater generic drug use (by end June)"(Letter of Intent March 2013, Point 14)</i>
Health 45. The authorities will set high level annual targets for increasing the share of generic drug usage in the medium-term. Enabling measures – such as compulsory prescription by International non-propriety name (INN) by Year end (in 8th update and end-October 2013 in 9th update), where appropriate – required for the achievement of these targets will be put in place and kept under further review. (8th update MoU April 2013 and repeated in 9th update)
<i>The implementation of generic substitution and reference pricing has been prioritised by the Department, the Health Service Executive and the Irish Medicines Board. Reference pricing is expected to deliver at least 50 million savings in 2014. The Health (Pricing and Supply of Medical Goods) Act 2013 also includes a process for the review of existing prices outside of reference pricing.(Final Letter of Intent 2013)</i>
Prescription and monitoring of prescription
Pharmacies sector
In relation to pharmacies "Ensure recent elimination of the 50% mark-up paid for medicines under the State's Drug Payment Scheme is enforced"(Original MoU December 2010. Pt 28)
Centralised purchasing and procurement
Primary care services
Eliminate restrictions on (i) the number of GPs qualifying, (ii) GPs wishing to treat public patients, (iii) GPs advertising (Original MoU December 2010. Pt 28)
<i>"Better target spending, particularly within the primary care re-imbursement scheme."(Letter of Intent, November 2012)</i>
Hospital services
<i>"Enhance hospital efficiency, by implementing major work practice and rostering reforms, reducing the average length of hospital stays, increasing the share of day treatments, and minimising unnecessary return visits for out-patients;"(Letter of Intent, November 2012)</i>
Entitlements
Comprehensive targeting of spending is needed to deliver immediate reductions combined with reforms to underpin savings in the medium term. Better targeting of medical card spending can generate significant savings while protecting the poor. (Concluding Statement of the IMF Mission July 2012)
Overall Budget Control
<i>"We have identified scope for reducing overtime payments including through smarter rostering for emergency services (such as health and police); rationalising allowances; and boosting public service productivity through changes to sick leave entitlements (p8)"(Letter of Intent, February 2012)</i>
<i>"We are on track to deliver a budget deficit within the 8.6% of GDP target in 2012. . . At the same time we are alert to pressures in health and social protection spending and will continue to manage expenditure to remain within budget (pt 13)."(Letter of Intent, August 2012)</i>
Health sector: Authorities to specify quantified measures to eliminate the spending overrun by year end. (6th update MoU September 2012.)
<i>"We are alert to the overrun in current health spending and are taking measures necessary to unwind it.(Letter of Intent, November 2012)- see other sections for details of response</i>
The authorities will take the measures necessary to unwind the overrun in health spending and will contain health expenditure next year to within the €13.6 billion departmental ceiling for 2013 set in the Comprehensive Expenditure Report 2012-14. (Point 8) (7th update MoU January 2013.)
<i>"We are implementing Budget 2013 in the same prudent manner. The bulk of the measures comprising the €3.5 billion consolidation effort have been enacted. . . Moreover, we have decided that the Health Service Executive and the Department of Health will report to the Cabinet Committee on Health on the implementation of the health sector measures on a monthly basis to actively prevent renewed slippages. (Letter of Intent March 2013)</i>
Cross services
Health sector (Point 38). The authorities will develop an eHealth Strategy in conjunction with the HSE by end Q2 2013. This will serve as a time-bound action plan for the implementation of eHealth systems, including a comprehensive system of ePrescription which uses a unique patient identifier, such as the PPSN—to support and enable the delivery of integrated patient care under the reform agenda. (8th update MoU April 2013 and repeated in 9th update)
Health 58. In line with the eHealth Strategy, the authorities will publish by end-October legislation in conformity with data protection law to enable the introduction of universal and unique health identifiers for patients and service providers as well as to facilitate the introduction of full ePrescription. (9th update MoU June 2013)
59. The authorities will adopt a framework by end-October to streamline and consolidate multiple and fragmented financial management and accounting systems and processes by end-October (9th update MoU June 2013)

public revenues and reduction of public capital spending. Mandated structural reforms included reducing the minimum wage, increasing the pension age, changing the basis for pension payments to average rather than final pay and removing barriers to competition in sheltered sectors, amongst other reforms [10].

Furthermore, the financial aid was only to be released if performance targets were met. This led to high-profile quarterly visits by the IMF to check on progress and approve next tranche of funds' disbursement. The government had to report more frequently, weekly and monthly, on a stack of key indicators around financial performance, cash balances, bank finances, public spending and public sector salary outlays [10].

In essence, Ireland had handed over economic sovereignty during this time period. Some initial attempts to reform the Irish economy had been made in 2008 and 2009 but these proved insufficient to address the diverse problems and weaknesses of the banking sector, public sector financing, the housing crisis and lack of government regulation.

Consequently, over this time, the economy experienced huge restructuring and turbulence. From 2007 to 2012, unemployment rate more than trebled from 4.6% to 14.7%. Over the same period, Government's consolidated gross debt increased from 25% of gross domestic product (GDP) to 120%. The Government deficit which had reached a striking 30.6% of GDP in 2009 was cut back to 7.2% in 2012. Furthermore the economy, as measured by GDP, contracted in 2008, 2009 and 2010 [11]. Public sector wages were cut back in the Croke Park agreement, alongside the structural measures indicated above.

This combination of an initially severe and protracted recession with a subsequent recovery is an important determinant of current health care system trajectory, as it will be seen later.

Demands related to health

Interestingly, health was given a fairly free hand; initially perhaps because of the myriad of challenges being faced (see Table 1). The only focus in the original Memorandum of Understanding (MoU) was the requirement of introduction of more competition in relation to GPs and the removal of mark-ups for pharmaceuticals supplied through community drug schemes. Nevertheless, these were quite small issues for the health sector and were probably more ideo-

logically driven than a substantive reform.

Instead, conditionalities were added into the subsequent MoU updates and most notably in 2012. In some cases these conditionalities were preceded, and responded to formally, by the Government. Hence it appears that rather than a set of conditions from the outset we have a negotiated dance around conditionalities on top of the Irish Government imposing its own set of health reforms. This dialogue can be seen most strikingly in the case of managing the overall health overspend and also bringing in reforms to lower the state's drug payment bill (Table 1).

For the former, the IMF highlighted in particular the high spending on "medical cards". Article IV review of the EU-IMF Programme of Support for Ireland (in July 2012) made explicit reference to concerns over spending on medical cards, but did not specify the nature of the measures required to control such expenditure³. Medical cards provided a safety net system for those in austerity, expanding rapidly to bring free care for those newly unemployed. However, the rapid expansion was a substantial financial burden to the state. The state may well have buckled under pressure to change eligibility criteria for medical cards more radically but a poor political performance for government parties in local elections shelved any potential for such volatile reform.

Nevertheless, the Government set about bringing austerity into the health sector with zeal, even with few specific conditionalities of the bail-out. Between 2009 and 2013 financing of the Health Service Executive, the central state purchaser of and implementer of health care, financing fell by 22% [7]. Staffing also fell sharply by around 8,000 with primary and community services particularly hard hit [12]. It also set about shifting costs of access back onto households through higher charges for inpatients and Emergency Department (ED) attendances, a new levy for all on prescription items, higher drug reimbursement thresholds, and reduced medical card coverage[7] see Table 2 where the section yellow highlights the bail-out era. Interestingly the Government is displaying a growing shift from medical cards to GP visit cards[5] as a means to reduce costs while promoting a shallower version of universal coverage. Such cost-shifting would certainly align with the evolving MoU.

3 - www.imf.org/external/np/ms/2012/071812.htm#P5_83



Table 2 - Changes to statutory entitlement in Ireland, 2009-2018

Year	Population with medical cards	Population without medical cards
2009	Automatic entitlement to medical cards removed from people over 70 years of age and replaced with a means test	Increase in charge for attending emergency department (without a GP referral letter) from €66 to €100; Increase in the public hospital inpatient charge from €66 to €75 per day (maximum per year €750) DPS: Increase in monthly threshold from €90 to €100 Tax relief on unreimbursed medical expenses restricted to the standard rate of tax (20%)
2010	GMS: Introduction of €0.50 charge per prescription item beginning in October (monthly cap €10) DTSS: dental entitlements reduced (beginning in April)	DPS: increase in monthly threshold to €120 TBS: dental and ophthalmic entitlements cut
2011	None	None
2012	None	DPS: Increase in monthly threshold to €132 TBS: aural entitlements cut LTI Scheme: Commitment to extended entitlement to free GP care as phase 1 of the free primary care strategy. Later replaced with alternative plan to extend universal GP care. Later deferred.
2013	GMS: Increase to €1.50 per prescription item (monthly cap €19.50) Lowering of thresholds for medical cards for those over 70 years of age (excluded 40,000 people)	DPS: Increase in monthly threshold to €144 Increase in the public hospital inpatient charge to €80 per day (maximum per year €800) The amount of private health insurance premium qualifying for tax relief limited to €1,000 for adults and €500 for children (including students aged 18–23 years in full-time education)
2014	GMS: Increase to €2.50 per prescription item (monthly cap €25)	Proposed free GP care for children 5 and under (delayed)
2015	None	Free GP care introduced for children aged under 6 years and reintroduced for adults aged over 70 (Summer)
2016	None	Proposed extension of free GP care to all children under 12 years of age (delayed and later withdrawn)
2017	GMS: Reduction of monthly cap on prescription charges from €25 to €20 for those over 70 years of age	TBS: €42 payment towards annual scale and polish; biannual entitlement to free sight test and €42 towards glasses
2018	GMS: Reduction to €2 per prescription item (monthly cap reduced to €20 for those under 70 years of age)	DPS: Monthly threshold reduced to €134 per month

Source: Johnston B, Thomas S, Burke S (2018), Moving towards universal health coverage: new evidence on financial protection in Ireland, Copenhagen: WHO Regional Office for Europe.

Notes: Yellow shading indicates Troika bail-out period. DPS: Drug Payment Scheme; DTSS: Dental Treatment Services Scheme; GMS: General Medical Scheme; LTI: Long-Term Illness; TBS: Treatment Benefit Scheme.

Necessary reforms vs burdens

GP reform to increase competition may have helped increase GP supply though prices remain very high. Drug costs are very high in Ireland and remain stubbornly so, partly because of the importance of the pharmaceutical sector to employment and its strong negotiating power in price-setting. In that area, the IMF stipulations were warranted. Expressed concerns over the medical card bill were not particularly helpful and could well have threatened the financial protection of vulnerable households by further destabilising an important safety net. What they pointed to was the need to universalise care but this is difficult to do within a context of austerity as the subsequent Irish experience has shown.

Instead the bulk of reforms from Government were home-grown, an eclectic mix of producing efficiencies from a bloated system and finding any means to reduce Government spending regardless of the financial burden to households or the inefficiency produced in the system.

Evolution of the population health status under the EAP

Health status key indicators show a definite impact of the austerity era (Figures 1-3). There is a definite drop in

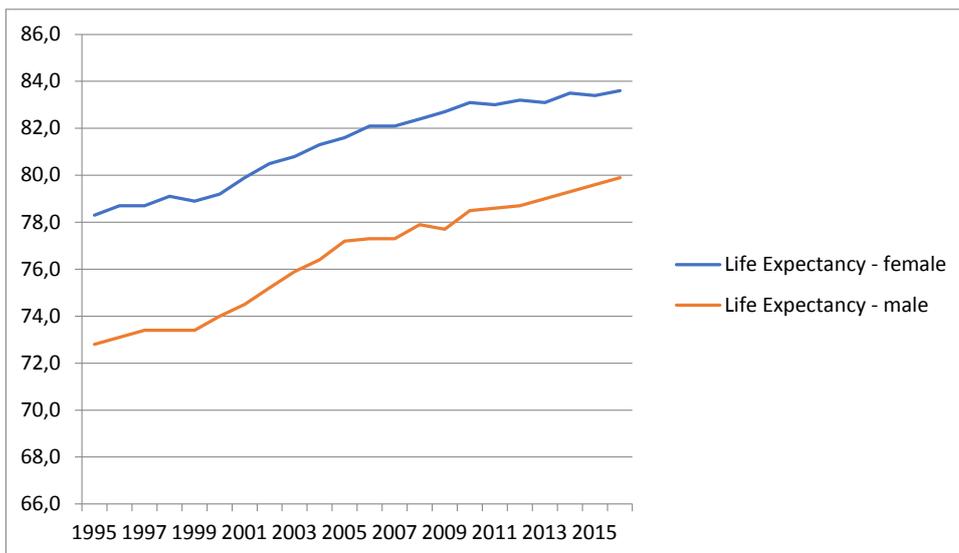


Figure 1 - Life Expectancy, Ireland (1995-2016)

Source: Eurostat

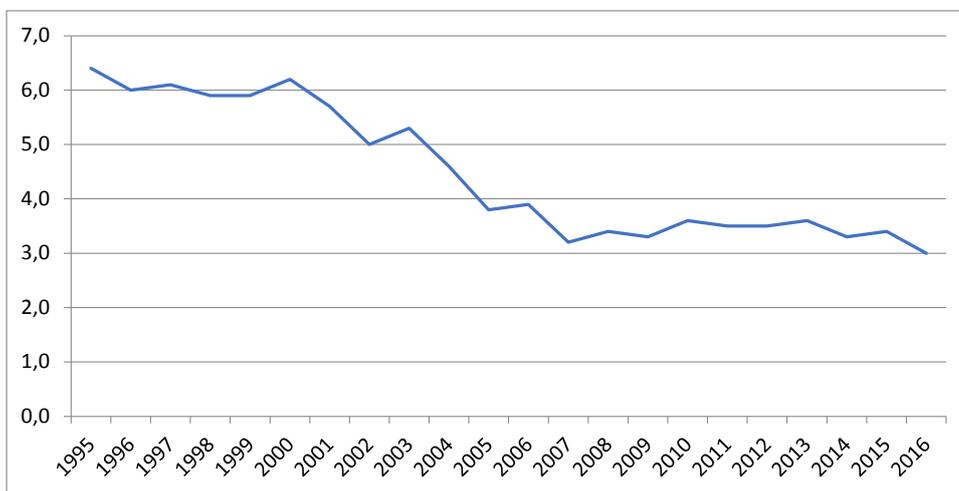


Figure 2 - Infant Mortality rate per 100,000 (1995-2016)

Source: Eurostat

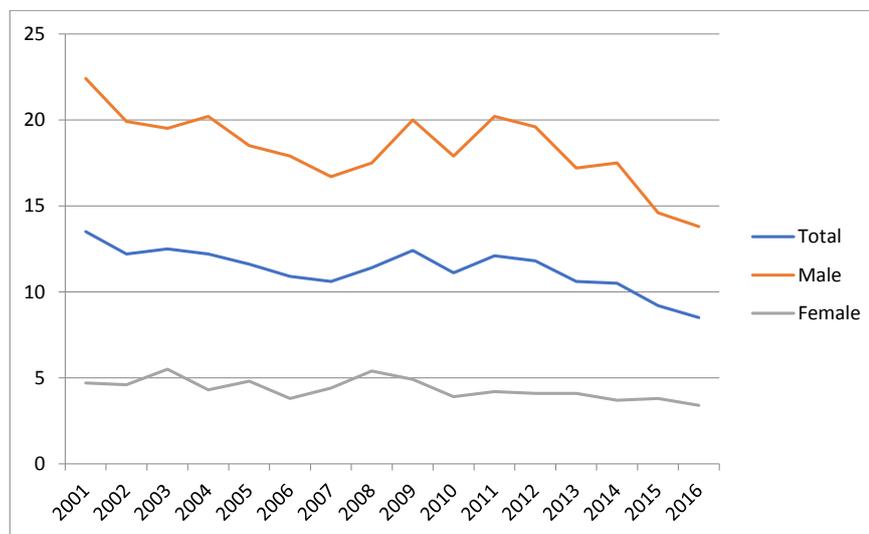


Figure 3 - National Suicide Rates for Ireland per 100,000, (2001-2016)

Source: Central Statistics Office, Ireland

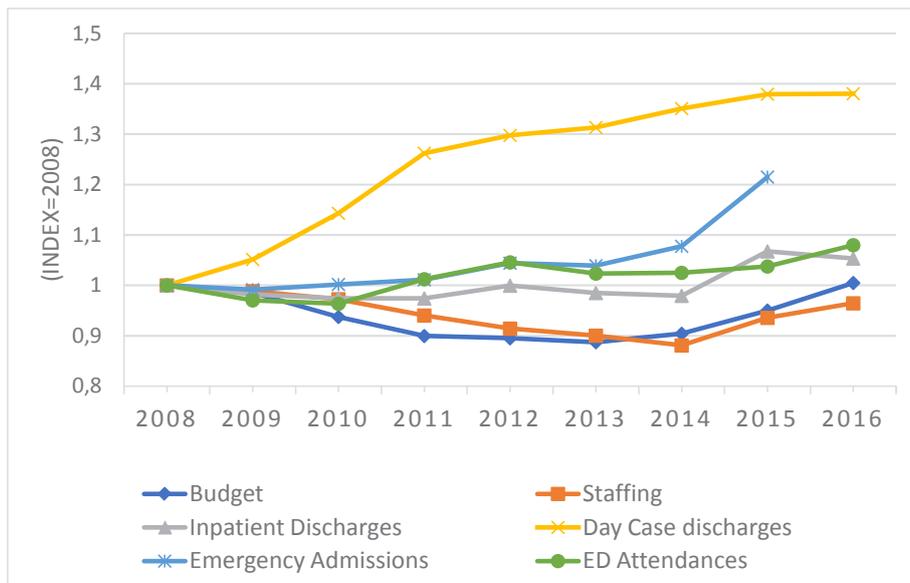


Figure 4 - Changes in Resourcing and acute indicators (2008-2016)
Source: HSE Performance Reports and TCD database

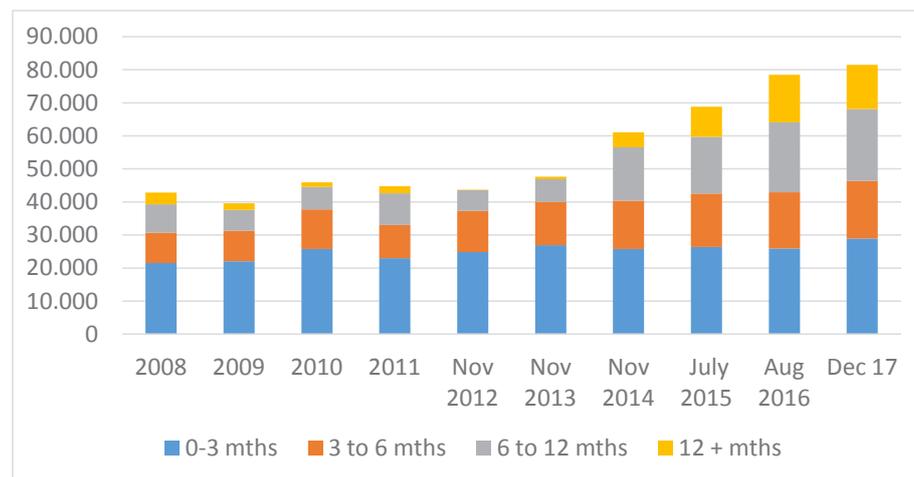


Figure 5 - Number of adults waiting for IP (Inpatient) and day-case hospital treatment (2008-2017)
Source: National Treatment Purchase Fund

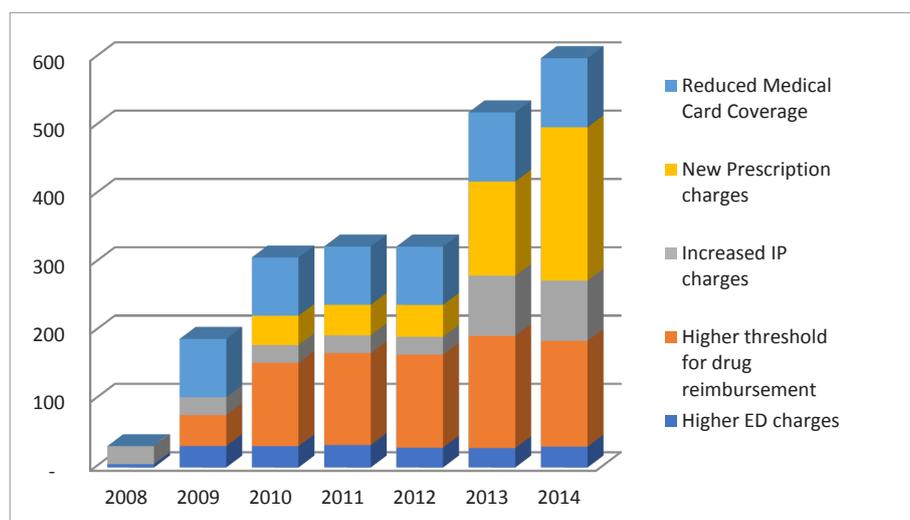


Figure 6 - Cost-shifting from the state to private households in € million (2008 to 2014)
Source: Updated graph from Thomas et al 2013

male life expectancy in 2009 to 77.7 from 77.9 in 2008. There is an alarming flat-lining in infant mortality rates after seven years of reductions, with individual annual increases in 2008, 2010 and 2013. Only in 2016, with the economy well back to recovery, do we see a return to a declining trend in the infant mortality rate. Furthermore, the national suicide rates show a strong upward movement in 2009 and 2011 for men and 2008 for women. Only after 2014 do the rates resume their previous downward trend.

Evolution of the health care system under the EAP

As can be seen from the earlier discussion and Table 1, a key concern for the MoU was to manage the health care overspending because of the hole in government finances. This was translated into quite radical reductions in health budget allocations (Figure 4). Some of this resource reduction was absorbed by providing care in low cost settings. For instance, there was quite a large shift towards treatment of patients in daycare settings with much more constrained activity on inpatient care (see Figure 4). Such a move represents an efficiency borne of austerity.

The resource reduction in the public health care setting was also absorbed by lowering unit costs, such as reducing salary levels for all government staff including public health sector employees. Indeed, given that the public health sector employs

over 100,000 people and is the largest employer in the country, then reducing salary levels will have a strong impact on the Health's budget. Furthermore, from 2009 there was a moratorium on hiring new staff, except for some protected professions, and a programme of voluntary redundancies with, for many, an attractive package for retrenchment (Williams and Thomas 2017) [12].

While Human Resources (HR) levels have now more than fully recovered to their pre-austerity levels (HSE 2018) there is a growing bias toward acute care and away from lower cost primary and social care settings. Hence, while there have been some moves towards efficiency a renewed focus on hospitals may actually produce inefficiency. As shown in Figure 4 there are increasing ED attendances and emergency admissions implying that primary and social care services are not being accessed appropriately and that people are not happy to wait on ever longer waiting lists.

The waiting list data for Ireland make grim reading. Ireland has no formal legislated waiting time guarantee, albeit a commitment to treat people within 15-18 months, poor data and little accountability in regards to wait times. It also has some of the longest waiting time for elective care in Europe. Figure 5 highlights that the situation has recently deteriorated in terms of a huge increase in the number of people waiting over 12 months for elective care in a public hospital setting. Waiting lists got worse with austerity, then came down slightly but have rocketed in recent years. This is partly due to capacity constraints and bed closures in public hospitals during the austerity period. It is also a consequence of an ageing population, increased numbers of frail elderly arriving at in ED and subsequent emergency admissions choking public sector elective capacity.

The impact of squeezing the Health's budget as prescribed by the MoU, is shown in Figure 6, where the extent of cost-shifting from the state to households is highlighted. Between 2008 and 2014 an additional €600 million of costs were incurred by households for accessing services and drugs that had previously been borne by government, equating to an additional €130 per person per year in additional OOP. Recent analysis of financial protection estimates that there was a 50% increase in the number of households experiencing catastrophic spending on health from 2009/10 to 2015/16 (Johnston et al 2018 WHO)

Key elements of the austerity programme need to be reversed to remove some of the financial burden on households, undo some of the cuts in services and restore pay and conditions of publicly employed or contracted staff. Table 2 indicates some small shifts towards this post-aus-

terity and the 2019 Budget also continues this trend in relation to reductions in the prescription charge (now free for some sections of the population and generally reduced by €0.5 per item) and the drug reimbursement thresholds (by €10 per family per month) alongside initiating discussions with GPs to reduce some of the austerity measures around their reimbursement. Nevertheless, the legacy of austerity is still very much in evidence in relation to resourcing.

Changes in health policy after the end of the acute crisis

Interestingly even during the bailout era a new government committed itself to a single tier system which guaranteed access based on need, not income. This was the first time such a commitment had ever been made. This was to be delivered through Universal Health Insurance (UHI), with a 'multi-payer' model of compulsory private health insurance, and free GP and practice nurse care[2]. Nevertheless, very little progress was made on this (see Table 2) over the austerity period and in the immediate aftermath. The only real expansion of entitlements was in July 2015 with the introduction of free GP care for children under 6 and the restoration of free GP care for people over 70. Furthermore, in November 2015, long-awaited costings of the proposed UHI model were published which found that it would cost between €666 million and €2 billion more than the current health spending [13]. The Health Minister concluded that this particular model of universalism is not viable stating it was 'not affordable now nor ever' [14].

This failure to progress towards universalism can be explained by the unrelenting pressure on the health system as a result of budget cuts since 2009 [2], as well as the managerial overload of coping with declining budgets while trying to produce reform[15] and the lack of specifics around design and implementation[2]. Nevertheless, the principle of universalism survived even if the model did not. While there was no commitment to introduce universal health insurance in the Minister of Health's priorities in January 2015, universal health care was prioritized.

The general election of February 2016 precipitated the next key change in health policy. No party had an overall majority and it proved impossible for any party to form a working majority coalition. Instead Fine Gael formed a minority Government with the support of independent parliamentarians, supported by a 'Confidence and Supply' agreement whereby Fianna Fail, the second largest party, agreed not to vote against the government on key



Figure 7

Source: Burke et al 2018

matters[16]. This collaboration between the two largest parties was heralded as ‘new politics’[17]. This unusual context changed the nature of political debate particularly around health care [16].

Indeed an opposition instigated motion to establish an all-party committee with a remit of agreeing a ten-year strategy for health reform, including the delivery of a single-tier universal health service and switching emphasis to primary and social care, gained the support of the majority of TDs. On the 1st of June 2016, a motion to establish an all-party Committee on the Future of Health Care was proposed by the Health’s Minister, which gained all-party support [18]. The Committee for the Future of Health Care was established. It was made up of 14 members from across the political spectrum and included Deputy Roisin Shortall the original author of the motion. The Committee’s work was informed by a public call for submissions, which were analysed thematically. The Committee held 30 public hearings and published two interim reports [19, 20], and received technical support from a team of analysts from Trinity College Dublin. Initially due to report in January 2017, the Committee was given an extension until May 2017 to complete its work [19, 20]

Slaintecare

The vision of the Oireachtas Slaintecare Report 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)’[21]. It specified that all residents would be entitled to a full package of services and that this entitlement would be backed by legislation alongside a wait-time guarantee so everyone in Ireland would be entitled to timely and comprehensive care, free or at low cost. It further detailed the phasing and costings required to deliver such care within the ten-year timeframe. The entitlements are to be expanded each year to allow both the necessary funds to be in

place and for the system to adjust to the new capacity which would be needed. Indeed the reports proposed an Integrated Care Approach which concentrates on expanding primary and community care capacity and moving care when appropriate to the lowest level of complexity[16].

The report recommends the creation of a single National Health Fund. This would combine general taxation revenues as well as some earmarked taxes

and levies. Overtime, an increased proportion of the overall health budget would come from public, pooled resources and less from private OOP. This would bring Ireland close to the top performers in the EU in terms of funding healthcare from pooled public resources (moving Ireland from 69% publicly funded to 81%)[16]. The expansion of entitlements are estimated between €385 and € 465 million per year for the first six years of the plan though approximately half of this is switching funding from direct private payments to public taxation. A one-off transition fund, of €3 billion, is also required to make up for historical under-investment in health, and to fund the physical, programme and human resource infrastructure to deliver integrated care to match entitlement expansion. The policy process to develop the cross-party ten-year consensus plan was unusual as it was devised in the political domain and not by the Department of Health. Therefore, a critical aspect of the development of the policy was its formal adoption by the government and its publication of an implementation plan with resource commitments. This was not a foregone conclusion as while there was consensus on the committee not all politicians were as supportive.

More than a year after the publication of Slaintecare, in August 2018 the Government finally published its implementation plan and in September 2018 established an Implementation Unit with a Lead Director. Nevertheless, the implementation plan was weak on some aspects of Slaintecare. In particular, it talked about eligibility to care and not entitlements backed by legislation. Furthermore, it gave no detail on timing, phasing or funding of the expansion of care. It also ignored the need to invest in human resources to facilitate the expanded primary and community care delivery. In some ways the Implementation Plan is a step backward with far less detail about delivery than the original report while retaining a commitment to the overall vision and the principle of integrated and universal care. Furthermore, in the recent October 2018 Budget state-

ment for next year, there are some indications of Sláintecare type policies being promoted though not to the same degree or scale as in the original report. For instance, the Budget has extension of free GP care to 100,000 more people, based on their means, but the Sláintecare target was 500,000 for the same year. Hence there is evidence of a slower pace of implementation than was originally conceived and without some of the elements of system reform required, such as the introduction of a National Health Fund.

Protagonists of a progressive alternative

The Oireachtas Future of Health Care Committee report was unique in the history of Ireland's health policy in terms of creating political consensus on the way forward. This consensus has broadly held outside the committee in terms of the public statements of political parties. Nevertheless, it is obvious that some politicians in the larger centre right parties are less wedded to the principle of universalism. The current Minister for Health, even though from a centre right party does really seem committed to the project. Also virtually all academic and technical analysts in the health sector would be broadly supportive as well as those from international advisory agencies such as the WHO and the European Observatory. Elements of the trade union

movements are also supportive though not the doctors' trade unions. In particular, nurses would support the policy. Civil society would also be keen on Sláintecare[22] although it is recognised that there needs to be more engagement with the population over the issues. Sláintecare is a complex reform programme and people are suspicious of grandiose promises and the health sector is renowned for its intractable problems.

On the other hand there are a variety of vested interests whose reaction ranges from lukewarm to outright hostility. Many GPs have been very suspicious of the extra demands being placed on them and are still hurting after the austerity cuts resulted in reduced payments for service delivery. Consequently, the response of some GPs has been antagonistic. Many consultants would also have lucrative private practice and are horrified at the prospect of their private practice being taken out of public hospitals. The doctors' union, the IMO, is generally suspicious of the programme despite previous interest in universalism, probably because of the legacy of cuts, salary reductions and the perceived risk of change. The Ministry of Finance is also very sceptical about the affordability of Sláintecare and likes to paint the health sector as a black hole for resources. Hence the political picture is quite finely balanced with just enough support to get Sláintecare slowly moving but not enough momentum to guarantee its good health.

References

1. CSO, *Ireland's System of Health Accounts, Annual Results 2015*. 2017, CSO: Dublin.
2. Burke, S., Normand, C, Barry, S, Thomas, S., *From universal health insurance to universal healthcare? The shifting health policy landscape in Ireland since the economic crisis*. Health Policy, 2015.
3. Johnston, B., et al., *Private health expenditure in Ireland: Assessing the affordability and sustainability of private financing of health care*. Social Science and Medicine (submitted), 2018.
4. Mercille, J., *Privatization in the Irish hospital sector since 1980*. Journal of Public Health, 2018.
5. Brophy, S. and D. Lynch, *Government Expenditure on General Practice, in Spending Review 2018*. 2018, Department of Public Expenditure and Reform: Dublin. p. 1-19.
6. Keegan, C., Thomas, S, Normand, C, Portela, C., *Measuring recession severity and its impact on healthcare expenditure*. International Journal of Health Care Finance and Economics, 2012. DOI 10.1007/s10754-012-9121-2.
7. Thomas, S., Burke, S, Barry, S., *The Irish health-care system and austerity: sharing the pain*. The Lancet, 2014. 383 (3 May 2014).
8. Ryan, P., Thomas, S, Normand, C., *Translating Dutch: challenges and opportunities in reforming health financing in Ireland* Irish Journal of Medical Science, 2009. 178 (3): p. 245-248.
9. Thomas, S., Keegan, C, Barry, S, Layte, R, Jowett, M, Normand, C., *A framework for assessing health system resilience in an economic crisis: Ireland as a test case*. BMC Health Services Research, 2013. 13:450 (<http://www.biomedcentral.com/1472-6963/13/450>).
10. Barret, S., *The EU/IMF rescue programme for Ireland: 2010-2013*. Economic Affairs, 2011. 31(2): p. 53-57.
11. Nolan, A., Barry, S, Burke, S, Thomas, S, *Observatory-WHO study on the impact of the financial crisis on health and health systems in Europe. Case Study Ireland*. 2014, WHO European Observatory on Health Systems London.
12. Williams, D. and S. Thomas, *The impact of austerity on the health workforce and the achievement of human resources for health policies in Ireland (2008-2014)*. Human Resources for Health, 2017. 15 (1): p. 62.
13. Wren, M., Connolly, S, Cunningham, N. , *An Examination of the Potential Costs of Universal Health Insurance in Ireland*. 2015, ESRI: Dublin.
14. Department of Health, *Statement by Minister Varadkar following Cabinet discussion on UHI*. 2015, Department of Health: Dublin.
15. Barry, S., et al., *'Is someone going to saw off the plank behind me?' - Healthcare managers priorities, challenges and expectations for service delivery and transformation during economic crisis*. Health Systems, Policy and Research, 2017. 4 (1): p. 1-7.
16. Burke, S., et al., *Sláintecare – A ten-year plan to achieve universal healthcare in Ireland*. Health Policy, 2018.
17. Farrell, D. and S. Suiter, *The Election in Context*, in *How Ireland Voted 2016: the election that nobody won*, M. Gallagher and M. Marsh, Editors. 2016, Palgrave: Cham. p. 277-292.
18. Eireann, I.D., *Committee on the future of healthcare report: motion*. 2016, Houses of the Oireachtas.
19. Houses of the Oireachtas Committee on the Future of Healthcare, *Interim Report on the Future of Healthcare, August 2016*, H.o.t. Oireachtas, Editor. 2016, Houses of the Oireachtas: Dublin.
20. Houses of the Oireachtas Committee on the Future of Healthcare, *Second Interim Report of the Committee on the Future of Healthcare*. 2017, Houses of the Oireachtas: Dublin.
21. Houses of the Oireachtas Committee on the Future of Healthcare, *Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report, May 2017*. 2017, Houses of the Oireachtas: Dublin.
22. Darker, C.D., E. Donnelly-Swift, and L. Whiston, *Demographic factors and attitudes that influence the support of the general public for the introduction of universal healthcare in Ireland: A national survey*. Health Policy, 2018. 122 (2): p. 147-156.