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ARTICLE

Improving access to healthcare in Ireland: an implementation failure

Sheelah Connolly[1,2]

[1]Economic and Social Research Institute, Whitaker Square, Sir John Rogerson's Quay, Dublin 2, Ireland and [2]Department of Economics, School of Social Science and Philosophy, Trinity College Dublin, College Green, Dublin 2, Ireland
Email: Sheelah.connolly@esri.ie

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Abstract

There are significant barriers to accessing health and social care services in Ireland including high user charges, long waits and limited availability of some services. While a number of reform proposals have committed to improving access to health care, implementation of these proposals has been limited. The aim of this paper is to identify and discuss policy implementation failures concerned with improving access to health and social care services in Ireland. Four potential reasons for the repeated failure to implement stated reform proposals are identified including a failure to identify and address the practicalities of implementation, competing health care demands, the political cycle and stakeholder resistance. While there has been a shift in Irish health care policy documents in the last 10 years with increasing emphasis on ensuring access to health care based on need rather than ability to pay, a repeated failure to implement the proposed reforms raises questions as to whether there is a real commitment to improving access to health care.

Keywords: policy implementation; private; public

1. Introduction

Health care systems are constantly evolving reflecting changing health care needs and treatment options, as well as changes in the demographic, socio-economic and ethnic composition of the population, and political priorities. In Ireland, despite ongoing issues with the health care system, reform has been slow and piecemeal. While an essential first step in reforming a health care system is identifying the relevant problem and potential solutions, equally important is consideration of the practicalities of implementing the reforms. There is precedent in Irish health care policy of identifying reform proposals that are subsequently only partially implemented or not implemented at all (Cullinan *et al.*, 2021). This paper examines the failure to implement a range of reform proposals intended to improve access to health care in Ireland.

While many European countries moved towards universal health care in the first half of the 20th century, this did not happen in Ireland (Wren and Connolly, 2019). Instead, a means tested system was introduced with (largely) free health care provided to lower income groups, with others left to pay out-of-pocket, in particular, for primary care services. Some of the health and social care system reforms implemented in Ireland over the last 30 years have centred on a neo-liberal ideology (Mercille, 2018; Wren and Connolly, 2019) in particular, the promotion of the private sector. For example, government tax subsidies from the early 2000s promoted the growth of for-profit private hospitals, while opening up the formerly state-provided private health insurance (PHI) industry to competition, though mandated by EU legislation, promoted the growth of tax-subsidised for-profit PHI (Tussing and Wren, 2006). During the economic

downturn starting in 2008, the shift from publicly financed to privately financed health care was further compounded by the removal of the automatic entitlement to largely free health care for those aged 70 and above in 2009, and the introduction of prescription charges in 2010 to those that were previously exempt.

In 2011 however, for the first time in the history of the Irish state, an Irish government committed to the introduction of a universal health care system in Ireland where access to health care services would be based on need (Department of the Taoiseach, 2011). To date there has been relatively little implementation of the relevant policy proposals and access to many services remains problematic.

The aim of this paper is to identify and discuss policy implementation failures concerned with improving access to health and social care services within the Irish health care system. The next section will provide a brief overview of the Irish health and social care system, including discussion of three areas (primary care, hospital care and community-based care for older people) where policy documents have detailed reforms which sought to improve access to health and social care services, but where implementation of the proposed reforms have been limited. Section 3 will explore some reasons for the lack of implementation. Section 4 concludes.

2. The Irish health and social care system

2.1 Overview of the Irish health and social care system

The Irish health care system is a complex mix of public and private delivery and financing. Currently, there are two main categories of entitlement to publicly funded health care services. Those in 'category I' (medical card holders) are entitled to largely free public health care services, while those in 'category II' are entitled to subsidised public hospital services and prescription medicines but pay the full cost of general practitioner (GP) and other primary care services. In November 2005, a 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 based on an income means test, with the threshold for GP visit cards about 50% higher than for the medical card. In 2015, a GP visit card was extended to all children under the age of 6, as well as to people aged 70 and over. In 2021, approximately 31% of the population had a medical card and 11% had a GP visit card (Department of Health, 2022); the remainder of the population (57%) pay the full cost of accessing GP and other primary care services. Alongside the public health care system, Ireland has a voluntary PHI market. Approximately 45% of the population were covered by PHI in 2021 (Department of Health, 2022). PHI in Ireland is primarily supplementary in nature and mainly used to purchase private elective care (Whyte *et al.*, 2020).

There is also a complex public/private mix in terms of health care provision. GPs, for example, are largely self-employed private practitioners. Other primary care professionals are employed by the Health Service Executive (the provider and payer for publicly financed health care services in Ireland) and paid a salary. There are also privately financed (through out-of-pocket and insurance payments) allied health care professionals, some of whom work in both the public and private sectors (Eighan *et al.*, 2019). There is significant overlap between the public and private hospital sectors. Much private practice occurs in public hospitals, with over 50% of private in-patient bed days occurring in public hospitals in 2015 (Keegan *et al.*, 2018). In addition, the National Treatment Purchase Fund (NTPF), established in 2002, can purchase care in private hospitals for any publicly financed patient who had been waiting longer than three months for hospital services.

Most hospital consultants have contracts which permit them to conduct private practice in public hospitals. There are differing reimbursement methods for both consultants and hospitals for the treatment of public and private patients. For example, while hospital consultants are paid

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by salary for their public work, they receive fee-for-service for treating private patients. Public hospitals are paid for treating admitted public patients on the basis of the volume and complexity of cases (as well as some block payments) and paid by insurers on a per diem basis for private patients.

Similar to the health care system, the social care system in Ireland is a complex mix of public and private delivery and finance. For example, in the current model of home support services, individuals can apply to the Health Service Executive for such services (which are currently provided free at the point of use) or purchase private support (which may also supplement public home support) from private providers (Walsh *et al.*, 2021). Among the older population in receipt of home support services, approximately 25% is privately purchased, with the remainder financed by the Health Service Executive (Walsh and Lyons, 2021), though often delivered through private providers. Similarly, those requiring long-term residential care (LTRC) can apply to the Health Service Executive for the Nursing Home Support Scheme (NHSS) or can purchase such care directly from providers.

2.2 Barriers to access within the current system

In the current Irish health and social care system, there are many barriers to access; here barriers in three important areas – primary care, hospital care and community-based care for older people – are examined.

2.2.1 Primary care

With regard to affordability of primary care services, previous research has shown that Ireland performs relatively poorly having the highest formal co-payments for primary care among 31 European countries examined (Kringos *et al.*, 2013). Recent analysis estimated that the average price of a GP visit was €53.55 for those without a medical or GP visit card (Walsh *et al.*, 2021) and there is evidence that these out-of-pocket payments may be deterring people from visiting the GP. O'Reilly *et al.* (2007), for example, found that in Ireland almost 19% of patients (4% of non-paying patients and 26% of paying patients) had a medical problem in the previous year but had not consulted the doctor because of cost. Among paying patients, it was the poorest and those with the worst health who were more affected.

For those with eligibility for primary care services free at the point of use (e.g. medical card holders), long waits can limit access. In December 2020, there were almost 40,000 people waiting for an occupational therapy appointment, 50,000 awaiting a physiotherapy appointment and 12,000 awaiting a psychology appointment (Walsh *et al.*, 2021). While these numbers refer to people on a waiting list, the actual number experiencing an unmet need for these services is likely to be greater, as some people may not be referred for a service if the service is not available within their particular area or if the waits are very long (Walsh *et al.*, 2021).

2.2.2 Hospital care

In Ireland, all residents are entitled to free or subsidised public hospital-based services. However, despite having a relatively young population, waiting times for publicly financed hospital-based services in Ireland are long and growing. Recent analysis by Brick and Connolly (2021) showed that a significant proportion of people waited more than 12 months for treatment in 2018, with Ireland performing poorly relative to other European countries. The COVID-19 pandemic and the associated restrictions on non-COVID-related hospital activity in 2020 and 2021 have led to a further deterioration in waiting times during 2021 with more than 40% of those on the outpatient waiting list waiting more than one year (Connolly *et al.*, 2022). In addition, shorter waiting times for hospital-based services for those with PHI relative to those without PHI (Whyte *et al.*, 2020) give rise to equity concerns that access to hospital-based services is based on ability to pay rather than need.

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2.2.3 Community-based care for older people

Both Irish and international research (Costa-Font *et al*., 2009; Abramsson and Andersson, 2016; Kramer and Pfaffenbach, 2016; Fox *et al*., 2017) has repeatedly found that most older people prefer to remain in their own home as they age. In Ireland, several government documents acknowledge this; however, there has been a continued failure to implement policy which would support the provision of the formal and informal services that are necessary for older people to remain in their own home. A recent report, for example, using data from the 2016 European Union Survey on Income and Living Conditions, found that 33% of respondents in Ireland reported an unmet need for formal homecare services (Privalko *et al*., 2019). Donnelly *et al*. (2016) found significant inconsistencies across geographic areas in the provision of services for older people and noted that the present social care approach has not been resourced adequately to meet the needs of older people. In general, demand far outstripped what was available and discrepancies were found between the number of hours an older person had been assessed as needing and the number of hours of home care which were actually approved (Donnelly *et al*., 2016).

2.3 Reform proposal

Over the past 20 years, a number of policy documents have been published which outline proposals seeking (among other things) to improve access to health care in Ireland. In some cases, these were standalone proposals with a specific aim (e.g. tackling hospital waiting lists), other proposals sought to introduce system-wide reforms (e.g. Sláintecare), while further proposals sought to deal with a subset of the system (e.g. care for older people).

Various initiatives have been identified over the past 20 years to tackle long waits for hospital-based services. For example, the NTPF was established to provide more timely care for patients who had been waiting longer than three months for hospital treatment (Department of Health and Children, 2002). The NTPF-funded treatment was to be purchased from private sources in Ireland, or abroad if there was not the capacity or expertise in Ireland to carry out the procedure (Burke *et al*., 2019). While the scheme has contributed to shorter waiting times for some publicly financed patients, overall waiting times and numbers have persisted and escalated since the development of the NTPF (Burke *et al*., 2019). In 2008, in response to the long waits for hospital-based services and inequitable access between those with and without PHI, a 'common waiting' list for publicly and privately financed patients attending public hospitals was proposed (Health Service Executive, 2009). However, some 10 years after the publication of the guidelines, a review group noted that the common waiting list had not been implemented as intended: private waiting lists were kept separate from public ones and private patients appeared to be able to 'move up' the waiting lists ahead of public patients, usually through reclassifying the cases as urgent (Independent review group, 2019). Later analysis found that there was no evidence that the 2008 proposed reforms reduced the differential in waiting times between those with and without PHI (Whyte *et al*., 2020).

In terms of whole system reforms, in 2011 a newly elected government 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' (Department of the Taoiseach, 2011). The 2011 Programme for Government proposed a significant reform to the health care system which would be financed, in part, by universal health insurance (2011). The proposals were not implemented in part due to concerns around the cost implications of the proposals (Department of Health, 2015a). However, free GP care was introduced in 2015 for all those aged less than 6 and 70 and over.

In 2016, an all-party parliamentary committee (Committee on the Future of Healthcare) was established with the aim of achieving a single long-term vision for health care and the direction of health policy in Ireland. The Committee's final report (Sláintecare) was published in May 2017 (Houses of the Oireachtas Committee on the Future of Healthcare, 2017). Amongst other things,

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the report recommended a 10-year reform programme which would include the introduction of universal GP and primary care as well as the removal of private practice from public hospitals. To date, relatively little progress has been made in implementing the Sláintecare reform proposals.

User charges remain for the majority of the population for GP and other primary care services. While Budget 2023 made provisions for extending GP visit cards to six- and seven-year-olds and all those below median Irish incomes, it is not clear when or if these proposals will be implemented. Progress in removing private practice from public hospitals has also been slow. While a new consultant's contract has been published which would only allow consultants to treat public patients, it remains to be seen how many consultants will avail of the new contract given strong opposition to some aspects of the contract by existing consultants (Dwyer, 2021).

In 2018, the government committed to the introduction of a statutory home support scheme by 2021 (Government of Ireland, 2018). However, little detail was provided on how the scheme would operate in practice including the potential use of user charges, how assessments for need would occur and how the scheme would be regulated. While four areas were chosen to pilot the statutory homecare scheme in 2021, the national rollout of the scheme has now been pushed out so it remains to be seen if the scheme will be implemented and to what extent it will address unmet needs for homecare services in Ireland.

3. Reform proposals but limited implementation: why?

It remains to be seen if, and to what extent, recent reform proposals seeking to improve access in the Irish health and social care system will be implemented. However, the question arises as to why Irish policy continually identifies reform proposals which are at best partially implemented. Here four reasons for the repeated failure to implement stated reform proposals are discussed. These include a lack of policy preparation, competing health care demands, the political cycle and a lack of demand (or resistance) from relevant stakeholders.

3.1 Lack of policy preparation

Hudson *et al.* (2019) have noted that a lack of policy preparation including a poor understanding of the underlying problem, insufficient knowledge of the implementation context, unclear and contradictory goals and poor-quality evidence can contribute to policies not being implemented. In Irish health care policy, there are several examples of proposed policies which lack clarity about what the reform proposals might mean in practice. In the Sláintecare report, for example, there is ambiguity about whether universal health care implies access to care that is free at the point of use (Connolly and Wren, 2019). While the report initially adheres to the principle that 'care should be provided free at point of delivery based entirely on clinical need' (Houses of the Oireachtas Committee on the Future of Healthcare, 2017: 43), the report later adopts a definition of universality which does not make reference to out-of-pocket payments [e.g. 'A universal healthcare system will provide population, promotive, preventative, primary, curative, rehabilitative and palliative health and social care services to the entire population of Ireland, ensuring timely access to quality, effective, integrated services on the basis of clinical need' (p. 58)].

Similarly, in relation to home care for older people, while a commitment was made to the introduction of a statutory home support scheme in 2022, there is still (April 2023) a lack of clarity about the scheme, including the extent of user charges and how additional demand will be met given workforce shortages. Without a clear description of what the policy will mean in practice, it is impossible to identify how the proposals would operate, the cost implications for both the exchequer and the individual, as well as the potential impact on demand for services.

Often health care policies appear to have been developed without proper consideration of whether they will solve (in full or part) the problem they are seeking to address. For example, a central component of the current Sláintecare reform proposals is the extension of free GP

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care to the total population. Such a reform would reduce financial barriers to accessing health care; however, there has been a failure to consider how the removal of such barriers might impact on the demand for services. Previous research for Ireland has shown that removing financial barriers increases demand for GP visits (Nolan, 2008; Nolan and Layte, 2017; McDonnell *et al.*, 2022). Consequently, given expected shortages in the number of GPs in the coming years (Teljeur *et al.*, 2010; Crosbie *et al.*, 2020), there is a need to significantly increase the number of GPs to meet the additional demand that would arise should user charges be removed. Failure to do so will likely result in the situation where people have, in theory, an entitlement to a service but are not able to access the services in practice, thereby undermining the universality of the system. Another example of a failure to consider whether the reform will solve the issue it is seeking to address relates to the Sláintecare proposal of removing private care from public hospitals. While one of the aims of the proposal is to ensure more timely access to public hospital care for publicly financed patients, it is not clear how successful such a policy would be in freeing up capacity. For example, a significant proportion of private in-patients in public hospitals are emergency in-patients and it is unlikely they could access the care they require in private hospitals meaning that such patients would likely become publicly financed patients within the public hospital system (Keegan *et al.*, 2018) rather than private patients within the private hospital system.

3.2 Competing health care demands

Long-term health care system reforms (such as those discussed in Section 2.3) often require significant amounts of additional resources, including funding and staffing. However, a range of competing demands can often absorb resources that might otherwise have been available to support reform. In Ireland, a growing and ageing population will contribute to significant increases in the demand for a range of health care services in the coming years (Wren *et al.*, 2017), and with it significant increases in health care expenditure (Keegan *et al.*, 2020; Walsh *et al.*, 2021). Recent Irish analysis, for example, estimated that the cost of extending eligibility for GP care that is free at the point of use to the whole population would be between €462 and €881 million in 2026 (Connolly *et al.*, 2023). Even if the financial resources were available to meet this cost, the question arises as to whether there would be a sufficient number of GPs available to deliver the additional demand associated with an ageing and growing population, as well as the increase associated with a further extension of eligibility (Connolly *et al.*, 2023).

On the supply side, factors including the development of new technologies and pharmaceutical products will likely have significant budget implications in the coming years (Walsh *et al.*, 2021). Such technologies which offer the potential of immediate health gains may be given higher priority when decisions are being made on the allocation of scarce resources than longer-term health care system reforms where benefits may not be as immediately apparent.

Factors external to the health care system can also impede long-term health care reforms. In Ireland, the 2008 economic recession led to significant cuts to the health care budget between 2009 and 2013. This resulted in significant cost-shifting for health care services from government to patients (Thomas *et al.*, 2014) including the removal of the automatic entitlement for a medical care for those aged 70 and over, thereby undoing previous measures which had attempted to improve access to health care.

Another external factor – the Covid-19 pandemic – had significant implications for the health care system. In the face of such a major shock, resources were directed towards the immediate threat rather than longer term health care reforms. However, in some cases, it might be possible for an external shock to provide a window of opportunity which facilitates reform (Kingdon, 1994). Universal health care has been introduced in some countries following external shocks including France and Japan where universal health care became more of a priority after World War II (Reich *et al.*, 2016), while in China, progress towards universal health care was achieved

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following the SARS outbreak (Yu, 2015). 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 (Reich *et al.*, 2016).

In 2020, some of the measures introduced in Ireland to deal with the pandemic were closely related to the Sláintecare proposals including increasing capacity within the public system (Mercille *et al.*, 2022) and the introduction of Covid-related GP consultations free at the point of use. While these and other measures sought to improve access to health care during the pandemic, their subsequent removal raises the question as to whether the window of opportunity offered by the pandemic still exists.

3.3 Political cycle

A failure to implement policies can also arise due to a lack of political commitment to implementing the reforms. Often policy makers are not accountable for the outcomes of their policy initiatives as they have moved on from the position they held when the reforms were developed. This can lead to the development of policies as quickly as possible, rather than getting involved in the protracted details of how things might work out in practice (Hudson *et al.*, 2019). Even when policy makers remain in position and could therefore be held accountable for the non-implementation of reforms, a lack of clarity about the practicalities of the reforms at the development stage can provide an opportunity for policy makers to avoid criticism as it may be difficult to identify if and to what extent the reform proposals have been implemented. The recent Sláintecare proposals provide an interesting example in this context in Ireland. Given the ambiguity about the definition of universality that underlies the Sláintecare proposals and whether a universal health care system will continue to include out-of-pocket payments, it will be difficult to identify the extent to which the proposals are implemented, thereby making it difficult for policy makers to be held accountable for non-implementation.

From an ideological viewpoint, Ireland has tended towards a liberal perspective which emphasises the provision of services via the market with limited, targeted support for the most vulnerable (Privalko *et al.*, 2019). In terms of health care policy, up to 2011 many health care reform policies supported the development of the PHI market (Turner, 2015). For example, policies such as the development of the NTPF to tackle long waiting times for publicly financed hospital-based services favoured the use of the private market to tackle an issue within the public system, while increasingly the provision of both home supports and LTRC for older people is being delivered by private providers. The lack of a universal health care system in Ireland points to an acceptance of a somewhat residual role for the state in health care in providing a safety net for those who otherwise would not be able to afford health care. While policy documents have changed in the last decade to reflect a commitment to universal health care, with access to services based on need rather than ability to pay, it remains to be seen if there is sufficient political will to implement the relevant reforms.

3.4 Stakeholder resistance

There are a number of stakeholder groups for which the *status quo* might be preferable to significant reform of the Irish health care system, including members of the public, health care providers and health care officials.

Previous analysis found that 87% of people participating in an Irish survey were in favour of the introduction of universal health care in Ireland (Darker *et al.*, 2018). However, it is not clear if people in asserting their preference for universal health care considered the potential implications on their own ability to access health care under such a system. Currently, those with PHI can bypass aspects of the public hospital system by accessing private care within both public and

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private hospitals. If the introduction of universal health care in Ireland includes the removal of private practice from public hospitals (thereby reducing the ability of those with PHI to access private services), those with PHI may prefer a continuation of the *status quo* rather than supporting reforms that will likely require an increase in taxation (O'Mahony, 2021) and potentially impact on their ability to access health care in a timely manner. Recently, objections were raised by members of the public (and medical professionals) about the removal of private maternity care from public hospitals with some arguing that this would reduce choice for patients given the lack of private maternity hospitals (Malone, 2023). In order to ensure buy-in from the public, it will be necessary to promise and deliver a high-quality public health care system which provides appropriate care in a timely manner so that all individuals are willing to contribute to and use the public system.

Stakeholder resistance to reform can also come from health care providers. In 2015, more than 92% of GPs signed up to the contract providing for GP visits free at the point of use for the under sixes (Department of Health, 2015b). However, initially the proposal was opposed by some GP organisations (Goodey, 2015) due to concerns about the equity implications of extending eligibility for GP care based on their age rather than income, and the potential impact of increased demand following the removal of fees.

A key recommendation from the Sláintecare report was the removal of private practice from public hospitals in order to increase capacity within the public system. Progress in this area has been slow. In December 2022, a new consultant's contract which would only allow consultants to treat public patients in public hospitals was approved by the government; however, doctors organisations have not yet agreed the new contract (April 2023) (Leahy, 2023) and it remains to be seen how many consultants will avail of the new contract.

Finally, resistance to refrom might come from health care officials who are responsible for the formulation and implementation of reform proposals. In Ireland, the Department of Health has overall responsibilty for the Sláintecare proposals. However, in 2018, the Sláintecare programme implementation office was established to drive the reforms. Key resignations in 2021 from the implementation office means that it is now less clear who is responsible for driving the reforms. Without a very strong desire and commitment to implement reform from health care officials, it is likely that resistance from other groups, competing health care demands and challenges, as well practical difficulties in implementing changes will result in the non-implementation of reform proposals.

4. Conclusions

Ireland remains an anomaly in Europe in failing to provide access to health care based on need rather than ability to pay. While a number of reform proposals committing to improving access to health care have been published, implementation has been limited and access to a range of health care services remains problematic. Much has been written about what is required to ensure successful policy implementation (Australian Government, 2014; Hill, 2014; Cairney, 2016; Ansell *et al.*, 2017; Hudson *et al.*, 2019), including ongoing collaboration with relevant stakeholders and identifying policy approaches after the problem has been defined, the options evaluated and consultation undertaken (Ferris, 2015); many of which have been lacking in the development of Irish health care policy. Further, the successful implementation of policy requires a political commitment to implementation as well as a commitment from health care officials. While there has been a shift in Irish health care policy documents in the last 10 years towards the proposed introduction of universal health care, a repeated failure to implement the proposed reforms raises questions as to whether there is a real commitment to improving access to health care in Ireland among a number of groups. Action to improve access to health care services is urgently required as population ageing and growth is projected to significantly increase demand for all health care services in the coming years.

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Note

[1] There is no one definition of universal health care and different commentators interpret the concept differently (Stuckler *et al*., 2010). The European Union have noted that '*Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need regardless of ethnicity, gender, age, social status or ability to pay*' (Council of the European Union, 2006) suggesting a definition of universal health care as one where access to health care services is based on need rather than ability to pay.

Competing interest. None.

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