How Ireland is Fixing Its Healthcare System – And What the U.S. Can Learn

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Welcome to **Code WACK!,** where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.**

(music)

This time on Code WACK! In honor of St. Patrick's Day, we're featuring Ireland's healthcare reform agenda known as Sláintecare. What healthcare challenges have plagued the country – and how will Sláintecare help? To find out, we interviewed Dr. **Sara Burke,** associate professor and director of the Centre for Health Policy and Management in Trinity College Dublin's School of Medicine. Her research

interests include health policy, inequities in health, healthcare access and the politics of health reform.

Welcome to Code WACK! Sara!

Burke: Thank you very much. Lovely to be here.

Q: This St Patrick's Day, when we say Sláinte or cheers, we're celebrating Irish health care. Can you give us a brief overview of Sláintecare and how it aims to transform Ireland's healthcare system?

Burke: Sláintecare is a 10-year plan for health reform that was devised through political consensus and that political consensus I think is key to it. So there was a parliamentary committee of all colors and creeds that came together to devise the plan, and one of the logics of the plan was that every time there was a new government or even a new minister – 'cause sometimes there can be a couple of different ministers within one government – there was a new plan. It kept on changing and there was never time for a plan to embed and give the system time to actually reform. And there were persistent issues like poor access to care, long wait times to access care, inequalities in who got access to care and these were of particular concern to the politicians who set up the group and to the terms of reference and it specifically was given a remit to deliver timely access to a universal healthcare system cause In Ireland to this day, like the United States, we don't have universal access to care based on need.

It was set up under a new government but it was cross party and they took about a year to do their work. And then after that year, it was adopted by the government and it's been adopted by each of the governments since then. So, there's been two changes of government since then. So, its ultimate aim is to deliver timely access to a universal health system. But it's also about much more than that. It's about 'how do we do much better in population health, much more care in the community outside of the hospital' 'cause we know that treating people in hospital is most expensive and it tends to happen too late, so let's do it earlier in the community, closer to their home. There was a big component about taking private care out of the public hospital system and it started in 2018 but

then COVID came in 2020 and that was a big disruptor to the system. So it's been ongoing since 2018.

Q: Wow, okay. So why did it take so long for Ireland to catch up with other European countries that have universal health care?

Burke: Great question. I think it is a combination of when a lot of other healthcare systems did in Europe was post-World War ii and we were a small, very fragile democracy. We were just about 20 years old. The Irish Republic was formed in the early 1920s, but we were very poor, very conservative with a very strong Catholic church and policy decisions were made indeed similar to the arguments against Obamacare, in Ireland in the 1950s, not to go the route of other European countries. And we're really only coming to it late in the last 10 or 15 years. There's been a sort of political commitment to try and deliver on it and be on par with other European democracies.

Q: As you mentioned, Sláintecare is moving Ireland towards a universal and single tier system. How does it compare to fully single payer models like Canada's single-payer system?

Burke: In some ways it's similar, but the big difference is that Canada and indeed many models within Europe are insurance based and a lot of the money to fund them comes from employers and employees. Whereas single-payer model have better access and better outcomes and they're particularly good for equity. And we know that systems like the United States of America where there's huge amounts of private providers have the worst health outcomes. It drives, it incentivizes the wrong type of care in the wrong place. It overtreats people with money. It undertreats people without money where there's all that individual payments. It results in worse population health outcomes. Ireland could go for a Canadian or a Belgian or a different European insurance model, but this parliamentary committee goes to a tax funded model. And actually one of the reasons for that was that the previous government in place in Ireland in 2011 had proposed a new insurance based model and that didn't work. It never happened. It was a failed policy proposal and that was one of the reasons for the genesis of Sláintecare was that nobody really had a plan and then one of the politicians in opposition said, let's come together and devise a plan. But critical to that was

rejecting the previous model, which was much more similar to a Dutch or an American, or a United States model with these competing private providers and insurers. And there's good evidence to show that probably wouldn't work in an Irish context. So we went a tax-funded route.

Q: Got it. So what would be the biggest change, do you think, that people will actually get to experience?

Burke: I think the biggest change would be that people would access care based on need and not ability to pay, and that happens in some circumstances now, but not all and particularly not in relation to planned acute care. So long waits to get, so if you're in cancer care, you're in the public system, you're treated pretty well and maybe as well off in the public system as you are in the private system. You could argue against it. But by and large… Stroke care [is the] same. But for those hips and knees and cataracts and those – they're not small. If you have them and need them, they're a huge difference to your quantity of life and your ability to live well or not – and you can be waiting years for them publicly. Whereas if you have an insurance policy, you can get them in a matter of weeks or months.

So it's that access to care that would be on an equal playing field based on need. But also there'd be much more care in the community, much more management of chronic diseases. Chronic diseases are the biggest burden on the healthcare system now. Much more management of that locally with specialist nurses rather than having to go see a consultant in a hospital. A lot of people can be empowered to manage their chronic diseases at home with the remote advice of a good specialist nurse is worth their weight in gold. So much more of that sort of prevention, empowering patients looking after our own health.

Wow. Now granted the U.S. has major barriers to care, including waiting months sometimes for routine visits and specialists. And yet I'm surprised to hear that in Ireland, people are waiting years for knee and hip replacement surgeries.

Burke: Yeah, and that's also true for access to diagnostics for children with disabilities, child/adolescent mental health services. So there's areas where we have particular black spots for access and actually money won't even buy you

some of that care. It's only really provided publicly and there's postcode lotteries in terms of who gets access to it or not.

Q: Again, in America, there are also often delays in these areas. So children are having to wait years to get access to services for disability support and you said mental health in Ireland also?

Burke: Yeah, child and adolescent and also this over dependence for certainly across mental health services, this over dependence on medication and a medical model when we know that for a lot of people, access to good therapies can be life changing for them. And so huge difficulties with accessing good allied health professionals as well.

Q: So how would Sláintecare improve that situation for them?

Burke: Just with this much bigger investment in community teams. And that's that emphasis on at the moment in Ireland, we tend to divert all care into the hospital and actually we should really just be doing the stuff in hospital that needs to be done in the hospital. But we should be doing most mental health care, social care, management of chronic diseases prevention, secondary prevention. We really shouldn't be doing that in the hospital. We should be doing that in communities. A big role for general practitioners who are the gps, the doctors working the communities, working with these publicly funded primary care teams. That's the model in Sláintecare, and so I can go with my child or my mother to a clinic in the community and access that care without having to wait months or years to have that treatment too late in a hospital.

Q: So what have been the biggest political and industry obstacles to implementing Sláintecare and how are those being addressed?

Burke: It was more about a political opportunity than political obstacles. And I've just talked about that a little bit. So it was just this odd circumstance in 2016 when we were a very different system of electoral politics in Ireland. So we have this proportional single transferable growth proportional representation, which allows for a lot of small parties rather than in the United States. You have two major parties. So we've much more, and that was very purposeful in the foundation of,

of the state to reflect a more diverse Ireland. So we've lots of small parties, so no one big party was elected. And also the two major dominant parties have got less powerful over time. They held it for a long time, but they've [gotten] less powerful over the last hundred years. And obviously the party that's grown significantly has been Chin Fein. But there was no one party that could lead a government.

So there was a minority government for the first time in the history of the state. And so that led to this political situation whereby they've had no choice but to cooperate. So it was this window of opportunity and in a way that has been maintained, that has held in the absence of anybody really opposing it or coming up with a different plan. If you were to think of the obstacles and there was a parliamentary committee that devised a plan and myself and other researchers here in Trinity, we worked with that committee and obviously like all political committees, there's lobbying and people trying to influence them and industry being part of that. So I'm not saying that doesn't happen in Ireland and probably, the most powerful industry is the private for-profit healthcare providers who are making lots of money, not the extent of the USA, but it's pretty profitable to provide some aspects of healthcare here.

And also the medical consultants who practice privately or the other healthcare professionals who practice privately. But you don't get to see that. I think a lot of that happens informally rather than formally. So it'd be hard for me to say like there'd be, there'd have been formal policy processes like people making submissions and the majority of them would be publicly interested bodies. But obviously industry also plays a role there.

Q: So what role, if any, did public opinion and grassroots movements play in pushing for Sláintecare?

Burke: Okay, then the run up to the general election in 2016, health was the number one issue or it was amongst the top issues. But also we do the, what's called exit polls in Ireland. So when people walk out at the polling station, they're asked by researchers what affected your vote most in this election? And in that election and many elections up to that, the primary issue was health. It’s shifted now. I'd say it will be housing, I would think, in the next one. And maybe in the last, but then it was health. So there was an acknowledgement and a realization

amongst the politicians that this was a really big issue. That said, for the reasons I've outlined, it was very much a top down political process carried out by politicians and technocrats supported by academic researchers. And yes, there was a call for submissions from the public and months of public hearings, but it was very much a to- down policy making process.

One of the weaknesses of Sláintecare is that it doesn't have that people or it hasn't had that people's bottom up element to it, and just before Covid arrived in Ireland around this time, five years ago for those six, nine months before that there, the implementation of ***Sláintecare*** was really beginning to do that grassroots roots movement at a regional level, realizing that for this, we know that reforms are more successful in health if they're meeting population health needs, if they involve clinicians and carers on the front line, if there is that grassroots bottom up energy to them. So there was the beginning of that process being put in place and then COVID came. And so that suspended all of that for months or years. And I think it's still probably a missing element of the reform. And again, we've gone back to regions now again, they're implementing regions as part of the Sláintecare reforms. And I think the opportunity there is can they engage communities and people there to really buy into this reform 'cause I think it'll only be successful if that happens.

Q: How much of Sláintecare has been implemented so far? Can you sum that up for us?

Burke: <Laugh>? Hmmm, No, I can't <laugh>. It's an impossible question. 'cause What's happened is in a way, ***Sláintecare*** was a direction of travel and they started producing implementation strategies and action plans in 2018, 2019. And then there was covid. And the world really is a very different place since then than it was before. So what was relevant in 2016, 2017, 2018 is different now and in some levels the covid response escalated to launch care. We had huge public investment, billions invested in the health system, which was required to implement ***Sláintecare***. This big shift of emphasis on public health. People suddenly understood why public health matters 'cause of Covid and the type of disease that it was but also this bigger emphasis on care outside of hospital and the community 'cause We needed to keep the hospital beds for people who were

really sick. So in some ways it turbo boosted the plan and in some ways it slowed it. And in some ways it's altered it. The last minister and each minister was slow to adopt it, but then when they were in power for a while, they embraced it. But you could argue that they cherry picked aspects of it. But that's the nature of democratic politics if we elect people to be in charge and their minister. So, the system-wide reform as envisaged in the original ***Sláintecare*** has not been implemented. Parts of it have, but it's been very slow.

Q: Is there a specific timeline that they're following or are they just moving in that direction?

Burke: There have been timelines that they've put in place, sort of two, three-year strategies and they're up now. And I think they very much had to wait for a new minister to be in place. Our new minister actually is in America for the St. Patrick's Day celebrations right now. I would think that under the new minister there is a commitment to a ***Sláintecare*** implementation strategy and action plan. And so that'll be one to watch in terms of how much support there is for it, where is her area of emphasis. But we know certainly in an Irish context that it's very hard to do reform without that very high level political support. But I would hope and assume that the new minister will come in behind it, but we don't know. So that new strategy plan will be key to the next couple of years.

Thank you, Dr. Sara Burke of Trinity College Dublin. Stay tuned for next week when we continue our discussion with Sara about Ireland's healthcare reform efforts.

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