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EQUALITY OMITTED REFORM:

An exploration of ‘egalitarian’ and ‘efficiency’ principles in Irish health care provision within an institutionalist framework.

by

Patrick Malone

A thesis submitted to the School of Political Science and Sociology
In conformity with the requirements for
The degree of Doctor of Philosophy

National University of Ireland
Galway, Ireland
December, 2015

Supervisor: Dr Michelle Millar
Internal Examiner: Dr Tony Varley
External Examiner: Dr Vivienne Byers
Abstract

This thesis is an exploratory study of the theory and practice of equality in shaping modern policy conceptions of access and entitlement to health care provision. In most modern democratic societies, the principles of access and entitlement to sufficient health care services is characteristic of both a social right, which every citizen in society should possess, and an assurance, that in times of illness and vulnerability, social security is guaranteed. A central facet to the realisation of this principled obligation bestowed onto government is the degree to which a philosophical vision of equality permeates in the policymaking environment. Thus, a central question addressed in this thesis is the extent to which ‘equality’ featured as a core policy goal in successive health care reforms. Furthermore, this study also examines the degree to which achieving ‘efficiency’, in terms of both the infrastructural development of the Irish health services and the governance framework overseeing health service delivery, has paralleled with the instilment of an ‘outright’ egalitarian ethos in the policymaking trajectory.

Through the theoretical frameworks of: Egalitarianism; Efficiency; and Institutionalism, this study provides a comprehensive examination on the evolution of the Irish health care system in terms of applied policy and practices related to ‘equality’ and ‘efficiency’ in service provision. In particular, the institutionalist theoretical frameworks applied in this study provides some significant insights in respect to chronicling the origins and entrenchment of the core policy constructs which both shape and constrain modern conceptions on; equality of access and entitlement to health care provision in egalitarian terms. Central policy constructs reviewed in this context are: eligibility of entitlement to public health care services; incentivising of the private sector market in health care; and the public-private mix of two-tier access to health care services. In contextualising the research themes of this study in empirical practice; the qualitative data compiled from interviews conducted with key stakeholders in the Irish health care domain provides some rich insights into how these concepts are being perceived and addressed in the contemporary policymaking environment.

In this study, it is argued that equality has not been a core facet in successive health care reforms. As such, it is posited that the achievement of an outright vision of equality has been constrained due to the structures of ‘access’ and ‘entitlement’ being governed by a ‘mixed-motives’ system containing both libertarian and egalitarian precepts in health service delivery. In this context, it is evident that the primary egalitarian emphasis of policy actors has been to instil a spirit of fairness in health care delivery under an ethos of ‘equality of opportunity’ and ‘equity’. Under this framework, the policy focus has not been on universal entitlement, but rather to direct publicly funded health care provision towards those in most need; the lower-income groups and most vulnerable in our society. Furthermore, it is posited that the primary essence of health care reforms in contemporary times has been centred on the achievement of ‘efficiency’ in the governance structure whereby equality is perceived to exist in an ‘implicit’ rather than ‘explicit’ sense through policy goals such as; ‘positive’ patient outcomes and ‘quality’ in service delivery.
Acknowledgements

As I reflect on this challenging and deeply inspirational journey through my PhD studies, I appreciate that this research could not have taken place without the encouragement and enormous support of many people.

Firstly, I would like to express a deeply felt gratitude to my thesis supervisor Dr Michelle Millar. Michelle has been a great mentor and has always been more than generous in providing me with expertise, extensive knowledge, support and advice. I am especially grateful for the patience, kindness and inspiration she has afforded to me throughout the course of my PhD studies. Thank you for everything Michelle.

I wish to also thank Dr Liam Coen for his support and guidance at various stages of this research. Liam has always been very generous in providing me with fresh insights and thorough advice when needed. For that I am very grateful. Also, I would like to thank Dr Lisa Moran for her support and advice. Additionally, I would like to thank Professor Chris Curtin, Dr Anne Byrne, Dr Tony Varley, Dr Vesna Malesevic, Kay Donohue, Michael Donnelly and all members of staff at the School of Political Science and Sociology, NUIG for their encouragement, advice and support.

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To my parents, Peggy and Pat, I will be forever thankful for your love, support and constant supply of encouragement. You both have always been persistent in helping me in every way possible to fulfil my educational paths and life ambitions. My brother and sisters, Hazel, James, and Lorraine, in your own unique ways you are always a great source of encouragement and support to me. I will always be grateful and fondly remember the help, kindness and patience which you have all shown me during this challenging and exciting experience. Without all of your support and reassurance, this undertaking would not have been possible.
Statement of Originality

I, Patrick Malone, hereby certify that all of the work described within this thesis is the original work of the author. Any published (or unpublished) ideas and/or techniques from the work of others are fully acknowledged in accordance with the standard referencing practices.

Signed: Patrick Malone

Date: 17 December 2015.
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Chapter One

Introduction

1.1 Background context and rationale for this study.

This thesis is an investigative study of the Irish health care system within the academic discipline of political science. In particular, this analysis places significant emphasis on the theory and practice of ‘equality’ with regards to the concepts of *access* and *entitlement* to health care services. It also investigates the extent to which the drive towards achieving ‘efficiency’, in terms of the governance framework that oversees service delivery, has superseded the achievement of *equality of access* to health care provision. As such, emphasis is placed on accentuating how the instilment of ‘equality’ or an egalitarian ethos in the policymaking trajectory has paralleled with the infrastructural development of the Irish health service.

The World Health Organisation (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.” (WHO, 2015) In this sense, health care provision as an idealism can be characterised as both a *social right* that every citizen in society should possess and an *assurance* that in times of illness and vulnerability social security is guaranteed. In democratic societies, the obligation to provide health care as a social right rests on both the state (through government bodies and insurance systems) which assumes or contracts this responsibility and all citizens in contributing through general taxation (Social Justice Ireland, 2015: 172). Moreover, a crucial fundamental to the realisation of this ‘obligation’ is the degree to which an *egalitarian ethos* is instilled in the policymaking environment.

Generally, it is widely accepted that the more equal societies are, in terms of income distribution and wealth, the better the outcomes that come to be derived – i.e. health care and education. Hence, a strong interlinkage exists between economic and health inequalities. As such, this posits that high levels of economic inequality result in poor health outcomes for everyone in society, particularly those in the lower-income
groups (TASC, 2011: v). As a means of eliminating health inequalities, TASC (2011) report that policymakers need to emphasise on reducing the gaps between the highest and lowest occupational classes and the wealthiest and most deprived areas as a means of eliminating health inequalities in society. A significant precursor in this regard, which also forms a central point of analysis in this study, is providing ‘universal access’ to health care services on the basis of medical need rather than ability to pay.

In the Irish case however, universal access is restricted due to two underlying characteristics of the system: 1) the complex structures of public, private and voluntary healthcare providers operating in the health care arena; and 2) the vast majority of people having to pay for care (Burke et al., 2014: 2; Social Justice Ireland, 2015: 176). This is reflective of what Smith (2009: 4) describes as the ‘mixed motives’ system which is deeply engrained in the institutional structuration of Irish health service delivery. Within a mixed motives system, egalitarian values govern some features of the system while libertarian idealisms oversee others. In a system that is governed according to libertarian principles, health care is distributed on the basis of willingness to pay in the private market (i.e. utilisation of ‘out-of-pocket’ payments or private health insurance funds.). Egalitarian idealisms are present when the consumption of health care is detached from the payment of such care. In this systemisation, revenues from general taxation are utilised to fund health care services to the population on the basis of some criterion (i.e. medical need) (Smith, 2009: 4). Thus, when examining the core pillars of the Irish health care system, primary (GP care) and secondary (acute hospital care), a complex mix of libertarian and egalitarian principles are embodied in the structuration of the Irish health care system. Smith’s (2009) characterisations of egalitarian and libertarian principles contained in the primary and secondary care structures of the Irish health care system is surmised in Table 1.1 below;
Table 1.1: *Egalitarian and Libertarian Principles in the Irish health care system* (Source: Smith, 2009).

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<td><strong>Primary Care</strong></td>
<td>The Public funding of primary services for medical card holders.</td>
<td>The Private funding of primary care services by non-medical card holders.</td>
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<td><strong>Secondary Care</strong></td>
<td>All individuals are eligible to receive public hospital treatment. While medical card holders are treated free of charge, non-medical card holders are required to make co-payments.</td>
<td>Private hospital care (i.e. private/semi-private beds, direct consultant care etc.) is provided on a <em>willingness to pay</em> basis in both public and private hospitals.</td>
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When compared on the international stage, Ireland has been reported in 2012 to be the only country in the European Union (EU) that does not provide universal coverage to primary care services (World Health Organisation & European Observatory on Health Systems and Policies, 2012 cited in Social Justice Ireland, 2015: 176). On the contrary, the Irish health care system comprises of three main patient categories which are: those with medical cards; those with private health insurance and those without both. As such, Irish citizens who do not hold a General Practitioner (GP) visit card, approximately 60 per cent of the population (which takes no account of their ability to pay), are expected to pay the full costs associated with most primary care services and outpatient prescriptions – this accounts for €40-60 per each GP visit and up to €144 a month for prescription drugs. Hence, Ireland is considered to have an underdeveloped system of primary care. This is apparent when analysing practices surrounding ‘inequality of access’ which are crystallised when investigating the ‘access’ routes to medical treatment (Social Justice Ireland, 2015: 176). As the *Report of the Expert Group on Resource Allocation and Financing in the Health Care Sector* (2010) states, the current government policy which reinforces the two-tier system gives rise to serious inequities in access to care.

While acknowledging that 40 per cent of the Irish population hold a medical card (which enables those in the lower income groups access to primary care and hospital care without charge), the development overtime of a complex and discriminative two-
tier system of access to public hospital care has meant that fee-paying private patients gain swifter access to both diagnostics and treatment (Burke et al., 2014; Social Justice Ireland, 2015: 176). In September 2014, there were 2,018,000 people insured with inpatient health insurance plans. Thus, the overall percentage of the population with inpatient health insurance plans rests at 43.8 per cent, a decline from 50.9 per cent from its peak in 2008 (Health Insurance Authority, 2014 cited in Social Justice Ireland, 2015: 176). Notwithstanding the steady decline in recent years, Ireland’s heavy reliance on private health care insurance demonstrates that there is an acute dissatisfaction with the public health care system (Social Justice Ireland, 2015: 177). The inequality present in this regard is exasperated further when putting into context the relatively small contribution made by private sources of funding (i.e. insurance premiums) to overall health care financing (Smith, 2009: vi). Having developed an understanding of the core features which characterise the contemporary structure of the Irish health care system, this study critically examines the chronological evolution of this libertarian-egalitarian nexus with the intent of establishing a more concise understanding of the egalitarian ethos which governs health care policymaking in Ireland.

On a reflective note, the initial interest in pursuing this research study stems from my undergraduate education under the Bachelor of Arts degree programme in Public and Social Policy at NUI, Galway. From my studies of political science, sociology and economics I have developed a keen interest in exploring, both theoretically and empirically, the root causes of social inequalities in modern capitalist societies. Furthermore, my studies of applied policy and practice in Ireland marked the beginnings of a deep interest in highly topical issues and debates surrounding the governance of the Irish health care system and the inherent inequalities persisting within its structures of service delivery. As such, I have developed a critical understanding of the significance in which ‘access’ and ‘entitlement’ to quality health care services holds as a social right of citizenship and as a determinant to both; an individual’s active participation in society and opportunity to live a full and complete life span with a strong element of security in times of vulnerability. It is my belief that the Irish health care system, in its contemporary setting, is failing in this premise of delivering health care as a social right which does not discriminate against patients on the basis of ability
to pay and, perhaps more significantly, that assures equality of outcome in terms of health status across all individuals and socio-economic groups.

Developing this interest in applied policy and practice has led me on a journey of wanting to discover how philosophical principles of equality and discriminative practices of inequality came to be embedded in the policymaking framework. Through my foundational studies of public administration and various theories surrounding the policymaking process, I have discovered that institutionalism theory provides a succinct framework to facilitate a critical and in-depth analysis of the Irish health care system in this context. As such, its focus on the impacts of history, cultural norms and value systems and policy ideas on the structural environment (which shapes the behaviour and perceptions of policy actors in decision making) provides a solid basis to understanding principle idealisms and paradigms influencing the governance of the Irish health care system.

1.2 Aims and objectives.
The core research question of this study aims to critically examine the current policy practice and ethos of equality shaping the structures of the Irish health care system. Furthermore, this study aims to explore if a philosophical ethos of ‘equality’ features as a predominant facet influencing the policymaking environment and consecutive health care reforms. This study also seeks to investigate if the desire to achieve ‘efficiency’, in the governance structure of health care provision, supersedes the achievement of an outright vision of ‘equality’ in service delivery. In the trajectory of Irish health policymaking, interpreting the process of ‘continuity’, ‘institutional stability’ and ‘change’, within an institutionalist framework, forms a significant cornerstone of analysis in this study. Through analysing the structural constraints and limitations prevalent in the institutional environment of Irish health policy, this will facilitate an understanding of how policy actors overtime addressed complex concepts such as equality of access and entitlement to health care provision. As such, this study aims to examine how policy visions of equality and entitlement in this instance came to be embedded and sustained during the Irish health care system’s course of development. Furthermore, this study also seeks to explore how the concept of ‘change’ is interpreted
in the arena policymaking in terms of reviewing/renewing policy conceptions on equality of access and entitlement and in altering the governance structure that oversees health service delivery.

The following are the core objectives of this study:

1. What evidence is there to suggest that the concept of equality features as a central tenet influencing the policymaking environment of the Irish health care system?
2. In analysing the legislative enactments of the Health Acts, 1970 and 2004, what evidence is there to suggest that ‘efficiency’ in the governance structure formed a principled tenet during these periods?
3. In historical institutionalism terms, how do the precepts of ‘continuity’ and ‘institutional legacies’ structurally shape policy outcomes in Irish health service provision?
4. From the theory of sociological institutionalism, how do cognitive, normative and regulative structures provide institutional stability and in that process shape the scope of welfare provision?
5. In terms of discursive institutionalism and the conceptual role of ideas and discourse in the trajectory of policymaking, how can the process of change be interpreted in Irish health care reform?

1.3 Theoretical Underpinnings

In this section, I will outline the theoretical underpinnings which form the basis of this study.

1.3.1 Conceptualising the principles of ‘Equality’ and ‘Efficiency’ in the social provision of health care.

The conceptualisation of equality is one which has raised considerable debate within the theoretical fields of sociology and political science. In many respects, the modern conceptualisations of equality has derived from a transition of understanding inequality as being a ‘natural’ circumstance of human beings or a ‘taken-for-granted reality’ to a
notion whereby ‘moral justification’ is required in accounting for the social injustices produced in society. From the outset, this modern conceptualisation of equality owes its origin to both the French and American Revolutions which acted as precursors to progressive forms of social change and social movements for the reorganisation of societies. While it is attributable that the philosophical debate surrounding the conceptualisation of equality is ancient in origins, the ideal of ‘social inequality’ is a modern phenomenon. The concept of social inequality in many respects arises from the institutional elements which constitute modern citizenship. Within this contextualisation, the expansion of social rights of citizenship is inextricably linked with the desire to achieve equality in modern society. In this regard, while modern societies acknowledge that certain forms of natural differences exists between human beings, there is nevertheless a recognition within the political sphere of the need to instil social equality and in particular ‘equality of opportunity’. Hence, modern politics and the institutions of the state are projected as being continuously subjected to social pressures for the expansion of opportunities equally amongst citizens in society irrespective of ethnicity, sexual identity or age. As such, it can be assuaged that the pressures for social equality encapsulates within modern industrial societies a movement towards the instilment of universalistic citizenship (Turner, 1986: 18-19).

The ideal of citizenship in this instance coexists and expands with the growth of economic markets and more significantly the development of the nation-state itself. Essentially, this came to be affirmed through the French and American Revolutions mentioned above whereby in the strive to achieving equality there was a social movement towards the advancement of social membership irrespective of the particularistic attributes that characterise individuals (Turner, 1986: 20). For instance, the slogans of ‘liberty, equality and fraternity’ which came to symbolise the founding principles of the French Revolution (1789 cited in Turner, 1986: 20), whilst initially designed as a social movement to achieve equality in property rights against the traditional aristocracy, it later transformed to provide a modern basis for civil rights and as an essential perquisite to the achievement of social participation on an egalitarian foundation (Turner, 1986: 20).
Thus, the modern notion of citizenship encompasses a staunch commitment towards the achievement of equality. This in particular comes to be synthesised through its focus on achieving universalistic norms and a secular system of values to reinforce political claims and social obligations. Hence, a theoretical framework came to fruition whereby inequality came to be no longer accepted as ‘inevitable’ or as a ‘natural’ condition of social reality (Turner, 1986: 18-20). This theoretical construct was also a feature of the American Revolution (1765) where it is depicted that “…each man was naturally possessed of liberty and happiness on an equal basis” (cited in Turner, 1986: 20). Similar to the French revolution, the social movement occurring in America during this period established the formal basis for political freedom and a modern idealisation of equality being founded on universalistic social participation¹ (Turner, 1986: 20).

In this study, through an examination of the divergent egalitarian theoretical strands of: libertarianism; liberal equality; equality of capability/outcome; equality of condition; and equity (chapter 2) it will be investigated how each philosophical strand addresses social inequalities and the premise of ‘access’ and ‘entitlement’ to health care provision.

The concept of ‘efficiency’ in the context of this research primarily centres on the principles and practices associated with the model of ‘governance’ utilised in the arena of health care provision/implementation. Efficiency, in the organisation and governance of health care has proven to be a pivotal goal of successive governments within the health care setting. For instance, the OECD (2008: 273) reported that a central policy goal of the Irish government at the time of its publication was to provide;

“…[a] safe high-quality services that achieve the best possible outcome for patients. Key to achieving this objective is having the capacity to treat patients as soon as possible, as efficiently as possible by the appropriate mix of specialists and in the appropriate location. In some instances the best treatment option for a patient might be at the primary level with their GP or through a primary care team (which could include an occupational therapist, physiotherapist and/or psychologist). In other instances, convalescent, or step-down care in a non-acute setting, e.g. a

¹ The significance of social citizenship rights in shaping modern conceptions of social equality will be considered in more detail in chapter two.
nursing home, may be more appropriate. Acute hospital services should only be sought and provided where necessary.”

As such, maintaining capacity within health care provision (in acute, primary and step-down care) is a significant precursor to establishing an effective governance model of efficiency as a means of delivering optimal outcomes for patients. Furthermore, within a scientific and technological context, an additional driving force for efficiency stems from the ever-growing and increasing complexity associated with providing specialities and services to a dispersed population. In this context, expertise and treatment options have become much more specialised. As a consequence, the care given to patients requires a more co-ordinated and team-based approach whereby different teams of medical staff with divergent skills sets work together – consultants/surgeons, nurses, anaesthetists – and operate in tandem. From an efficiency and indeed a clinical perspective, demands for co-ordination – and team-working initiatives – advances with increasing specialisation (OECD, 2008: 274-75).

Hence, from these two examples of modern issues which face the institution of health care provision, it becomes apparent that a conceptualisation of ‘efficiencies’ is derived from the ‘optimal patient outcomes’ that are delivered through the prevailing model of public administration and its concurrent principles of governance. In chapter two, this study examines the core framework which is currently influencing the governance structure of the Irish health care system, namely the: New Public Management and the Strategic Management Initiative.

1.3.2 Conceptual definition of institutionalism.

As a theoretical variant, institutionalism forms a core aspect in the discipline of political science due to the premise that modern governance to a significant extent occurs ‘within’ and ‘through’ institutions. From this stipulation, institutions matter because they have the capacity to wield power and mobilise resources during the course of political struggles. Institutions are also said to matter due to the fact that they possess the capacity to shape and constrain political behaviour and decision making. Furthermore,
they also shape the ‘perceptions’ and ‘powers’ of political actors within the policymaking arena (Bell, 2002: 1).

In terms of defining institutionalism and institutional boundaries, proponents have stipulated that it is best not to depict an institution as a ‘thing’ but rather as a process or set of processes that mould human behaviour. It is for this reason that particular attention is attributed to the laws, customs and established practices within the institutional and organisational environment which in turn can play a crucial role in shaping the behaviour of policy actors (Bell, 2002: 1). Within a broad context then, institutions can be defined as the ‘rules of the game’, or more formally, as humanly devised constraints that shape human interaction (North, 1990: 3; Steinmo, 2008: 150). Essentially, these rules can be categorised as formal (in terms of constitutional rules) and informal (in terms of cultural norms and values). As such, there is broad agreement that when defining institutions it is important not only to focus on the ‘formal’ institutional forms and practices but also on the ‘informal’ routines and practices within the internal environment of the policymaking arena. The central reasoning for this dual focus on the formal and informal attributes is posited by Levi who states that “the most effective institutional arrangements incorporate a normative system of informal and internalised rules” (1990: 409 cited in Bell, 2002: 1). This is echoed further by North who stresses that the most noteworthy attributes of an institution are often informal;

“In our daily integration with others, whether within the family, in external social reflections, or in business activities, the governing structure is overwhelmingly defined by codes of conduct, norms of behaviour and conventions. Underlying these informal constraints are formal rules, but these are seldom obvious and immediate source of choice in daily interactions.” (1990: 36).

In this sense, the institutionalist approach is viewed as a process which goes to the ‘heart’ of the basic problem in political science because it addresses the balance regarding ‘how much weight ought to be given to the individual and to the institutional context within which decisions are made and to a larger environmental factors, such as culture, social norms and conventions’ (Keoble, 1995: 231-32). Institutionalism encompasses an approach which studies the role that institutions play in the determination of social and political outcomes. Hence, the basic premise underlying
institutionalist analysis is that all participants within the political process understand and accept the ‘rules’ that are in practice. In putting this into context, March and Olsen (1997: 141) state that;

“The core notion is that life is organised by sets of shared meanings and practices that come to be taken as given for a long time. Political actors act and organise themselves in accordance with the rules and practices which are socially constructed, publicly known, anticipated and accepted. Actions of individuals and collectives occur within these shared meanings and practices, which can be called institutions and identities.”

From this point, it can be articulated that the sole purpose of establishing institutions is to reduce uncertainty in everyday life through the instilment of ‘structure’ and ‘stability’. Therefore, institutions come to symbolise the constraint mechanisms which are devised by human beings and that in turn shape human interaction in society². Essentially, these constraints represent both what individuals are ‘prohibited’ from doing and in certain circumstances what they are ‘permitted’ to do in an institutional setting. According to this conceptualisation, institutionalism posits a framework through which human interaction occurs (North, 1990: 4).

Another significant element to be derived from the institutionalist school of thought is the establishment of ‘organisations’ as secondary bodies to the institutions established. In this context, it is important to note that no sharp analytical distinction exists between ‘institutions’ or ‘organisations’. Rather, the organisation is symptomatic of a ‘nested’ attribute within and shaped by the wider institutional arrangements (Bell, 2002: 2). Therefore, as North states, the organisation is in effect a reaction to the institutional structures prevalent in society (1990: 396). This is apparent when we analyse the costs that arise out of an institutional framework, whereby the policy...

² Additionally, the existence of institutions, in layman terms, can act as a guide to human interaction so that in the event of one wishing to greet friends on the street, drive a car, borrow money etc., one knows (or can easily learn) how to perform such tasks (North, 1990: 4).
outcome is not symptomatic of the framework, but rather of the organisation that developed as a consequence of that framework\(^3\) (North, 1990: 5).

The manner in which organisations come into existence and how they evolve is fundamentally shaped by the institutional framework. In this context, it is articulated that while the organisation established may have some influence on how the institutional framework evolves, the institution itself takes precedence due to it containing and controlling the underlying ‘rules of the game’.

Therefore, the focus on organisational structures in this sense is to facilitate an analysis of their role as ‘agents’ in the process of institutional change, whereby the primary emphasis is on the interaction between institutions and organisations (North, 1990: 5). In chapter three, this study delves into the variants of the ‘New’ institutionalist school of thought that are of particular pertinence to this study which are namely: historical; sociological and discursive institutionalisms.

**1.4 Discussion on Methodology and Research Design.**

In terms of methodological approach and research design, this study was primarily shaped by *qualitative methods*. From the outset, my aim was to investigate the ethos or discursive paradigm that shapes health policy outcomes in terms of *equality of access* and *entitlement* to health care provision. As such, the research design adapted in this context is *deductive* in focus (Bryman, 2008: 10). This is due to the core research question and aims and objectives being reflective of a desire to comprehend what egalitarian ethos or discursive paradigm dominates the policymaking environment of the Irish health system through existing theoretical frameworks on: egalitarianism, efficiency and the evolutionary process of public policy. Thus, this thesis makes a valuable contribution to the academic field of *applied policy and practice* in health care and *equality studies*. As the theoretical framework adapted provides a succinct understanding of how the structure of contemporary health care provision is a product

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\(^3\) In practical terms, these organisations include political bodies (such as a political party, county council, or a regulatory agency), economic bodies (such as firms, trade unions), social bodies (such as churches, clubs) and educational bodies (such as schools and universities) (North, 1990: 5).
of: prevailing philosophical conceptions on equality; historical legacies; cultural norms and cognitive frames; and discursive ideas and policy paradigms.

1.5 The investigative and analytical process.

The investigative and analytical process utilised in this research deploys both secondary data analysis and semi-structured interviews.

1.5.1 Secondary data analysis.

The secondary data analysis conducted in this study comprised of a comprehensive and critical review of: academic publications (i.e. published books and journal articles); policy documents and research papers. This review of the relevant literature and documents occurred in three distinct, although interrelated, phases which are outlined below:

Phase One:
2. Efficiency and Governance frameworks and its application to health care.

This phase reviews the literature, research papers and policy documents surrounding the theoretical frameworks of equality and efficiency in health care provision. In regards to equality, the objective was to engage in a review of relevant literature and research papers on the conceptualisation of equality in terms of social citizenship; the philosophical frameworks on equality; and finally how these frameworks address the concepts of access and entitlement to health care provision. The review of the literature and research papers surrounding efficiency centred on the governance frameworks of New Public Management and the Strategic Management Initiative. The primary objective in this instance was to uncover the core themes of governance to emerge from these perspectives and how health care policy is shaped in terms of policy initiation and implementation.
Phase Two:

*Institutionalist perspectives on the policymaking environment and shaping of policy outcomes.*

The primary focus in this instance was to provide a comprehensive review of the literature surrounding the theoretical cores of institutionalism. In reviewing the institutionalism theoretical literature, the primary objective was to develop a conceptual framework for investigating the institutional environment of the policymaking arena. Furthermore, a theoretical understanding was sought on how the behaviour of policy actors is shaped by existing structures and constraints within the internal institutional environment. Another focal point for the review of this literature was to examine the concepts of ‘continuity’, ‘institutional stability’ and ‘change’ in the Irish health policy environment. The literature reviewed was divided according to the three institutionalist perspectives relevant to this study. These perspectives are namely: historical institutionalism; sociological institutionalism; and discursive institutionalism. Each perspective and its contained literature focused on a specific aspect of institutionalism theory and its analysis of the policymaking environment.

Phase Three:

*Review of the ‘Critical Junctures’ which have shaped the development of the Irish health care system in terms of ‘equality of access’, ‘entitlement’ and ‘efficiency’ in health care provision.*

The review in this instance had a twin purpose: firstly to identify the critical junctures of health care reforms in relation to the concepts of *equality, entitlement* and *efficiency*; and secondly to contextualise these reforms in terms of the historical and social setting of Irish society during these periods. The literature was primarily drawn from the published works of political historians and social policy analysts’ accounts of the periods under review in this study.

1.5.2 Semi-structured interviews.

The qualitative methodological process also consisted of conducting twenty-two interviews with a variety of key stakeholders in the Irish health policy domain. The
diversity in the professional backgrounds of interview participants was reflective of my desire to ensure that a broad range of perspectives regarding core concepts and policy practices pertinent to this study were taken into account. The categorisation of interview participants according to profession is outlined in Table 1.2 below. All interview participants are anonymous and were referenced in the interview findings (chapter five) according to their assigned interview participant number (e.g. IP, 5). The majority of interviews took place on a face-to-face basis with a minority transpiring over the telephone. Interviews were recorded using a Dictaphone.

As an interviewing format, the *semi-structured interview* technique was chosen to allow participants greater *flexibility* in conveying their points of view pertaining to core concepts and policy practices associated with: *access; entitlement;* and *efficiency* in health care provision. Furthermore, as Bryman (2008: 437) points out, the flexibility of semi-structured interviews enables the interviewer to respond to the “direction interviewees take the interview and perhaps [adjust] the emphasis in the research as a result of significant issues that emerge in the course of the interviews.” Thus, this format of semi-structured interviewing enables the collection of rich and detailed answers from participants.

The discussion points of the interview were contained in the *interview guide*, which was sent to participants prior to the interview taking place. As Patton (2002: 343) points out, the interview guide proves to be a useful tool in the organisation of interview discussions as it ensures that the same line of inquiry is followed with each participant interviewed. Furthermore, the interview guide allows interviewers to explore, probe and ask questions while in the process building conversation within a subject area (Patton, 2002: 343). The interview guide utilised in this study (see Appendix I) was divided into three sections. In section one, the discussion topics centred on participants’ philosophical observations on equality and how consecutive Irish health care reforms addressed the principle of equality in policy and practice. The second section explored the participants’ observations on the principles of ‘efficiency’ in terms of policy outcomes and in light of the administration of health service delivery in recent decades. The final section of the interview guide centred on participants’ general observations
regarding concepts such as the ‘welfare state’ and ‘social provision’ in both an evolutionary and contemporary context.

Table 1.2: Categorisation of Interview Participants according to profession.

<table>
<thead>
<tr>
<th>Semi-Structured Interviews (Total 22).</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political Actors (Public Representatives and Ministers – past and present)</td>
<td>5</td>
</tr>
<tr>
<td>Administrative Actors (Department of Health and Health Service Executive Agency – past and present)</td>
<td>6</td>
</tr>
<tr>
<td>Policy Advisors</td>
<td>4</td>
</tr>
<tr>
<td>Academic Commentators – Health Policy Analysts</td>
<td>7</td>
</tr>
</tbody>
</table>

1.5.3 Analysis of data.

Following the completion of interviews, the recordings of the interviews were transcribed verbatim through using NCH transcription software. The following stage involved the deriving of core themes to emerge from the interview data that were pertinent to the overarching research questions and objectives of this study. As a computer assisted form of data analysis, Nvivo proved to be effective in both the storing of data and facilitating the coding of passages from the interview data, which later formed core research themes/findings pertinent to the study. The process of coding was accomplished through Nvivo’s inbuilt ‘nodes’ system. Nodes are defined by Nvivo operators as a “collection of references about a specific theme, place, person, or other areas of interest” (cited in Bryman, 2008: 570). Once an interview transcript is fully coded, the node incorporates references to the portion of documents in which the code appears.

Following the completion of the coding process, I then engaged in a practice of ‘content analysis’. As a method, it has been described by Holst, as “…any technique for making inferences by objectively and systematically identifying specified characteristics of messages.” (1969: 14 cited in Bryman, 2008: 274). In the context of this study, I began a process of deriving core themes from the findings which were pertinent to the
theoretical frameworks and the research questions. Through engaging in this process, new and previously non-considered research themes emerged which required further theorisation and tighter specification of the research questions. Upon completion of the analytical stage and writing up of the findings (inclusive of both secondary data analysis and interview data), a discussion and interpretation of the findings in light of the research questions and theoretical frameworks of this study was conducted. The investigative and analytical process adapted in this thesis is illustrated in Figure 1.1 below;
Figure 1.1 Research Process: Investigation and Analysis.

- Theoretical Frameworks
  - Philosophical perspectives on Equality and their application to Irish health care.
  - Efficiency and Governance framework and its application to Irish health care.
  - Institutionalist perspectives on the policymaking environment and shaping of policy outcomes.

- Research Questions
  - Core Research Question - Aims and Objectives.

- Findings: Phase One
  - Secondary data analysis of published books, journal articles, research papers and policy documents surrounding the Critical Junctures which have shaped the development of the Irish health care system in terms of equality of access, entitlement and efficiency in health service provision.

- Findings: Phase Two
  - Semi-Structured Interviews with political, administrative and academic actors in the health policy domain on core concepts and practices relating to this thesis.

- Analysis of Data
  - Interviews transcribed and then coded using Nvivo software programme. This was followed by the use of content analysis on the data collected.
  - Further theorisation and tighter specification of the research questions following data analysis.

- Interpretation of Findings - Conclusions
  - Discussion - interpretation of the findings in light of the research questions and theoretical frameworks.
  - Conclusion - Summary Conclusions; Discussion on Recommendations for Future Research.
1.6 Outline of Thesis.

The chapter outline of the thesis is as follows:

- **Chapter Two** reviews the relevant literature on the theoretical constructs of ‘equality’ and ‘efficiency’ and their application to Irish health care provision. The chapter firstly begins by exploring core concepts pertaining to modern conceptualisations of equality such as the expansion of *social citizenship rights*. Following this, the chapter then delves into some of the central philosophical variants of egalitarianism. This chapter also explores the distinction between ‘equality’ and ‘equity’ and the implications for the organisation of health service provision. In the latter part of this chapter, the principle of efficiency is conceptualised. As such, there will be a focus on the governance frameworks of the New Public Management and the Strategic management Initiative and its impact on both the shaping of policy outcomes/service delivery and the organisation of health services.

- **Chapter Three** conducts a review of the relevant literature surrounding the theoretical variants of the ‘new’ institutionalist perspective. The theoretical variants of institutionalism which are pertinent to the research objectives of this study are: historical institutionalism; sociological institutionalism and discursive institutionalism. Each institutionalist perspective contributes to the provision of a succinct theoretical framework for contextualising the environment of Irish health policymaking. In addition, this framework also enables the exploration of three core themes of significance in this thesis; the process of ‘continuity’, ‘institutional stability’ and ‘change’ in the evolution of Irish health care policy. More significantly, the theory of institutionalism provides a realisation that contemporary public policy is a product of: historical legacies and path-dependent processes; prevailing cultural norms and cognitive frames; and discursive ideas and policy paradigms.

- **Chapter Four** examines those critical moments in the history of social provision where decisions taken produced a policy trajectory which shaped the character and scope of social provision in an evolutionary sense. More specifically, this
study explores the critical moments of health care reform which had an indelible impact on influencing the ethos of equality and method of service delivery in contemporary times.

- **Chapter Five** presents the interview findings interviews conducted with participants from: the Irish political sphere – past Ministers and Public Representatives; Policy Advisors; Administrative officials – from the Civil Service and Health Service Executive Agency; and in the field of academia – Health Policy Analysts/Commentators. The interview findings reflect on themes such as: philosophical observations on equality; the ethos of equality in consecutive health care reforms; the principles of efficiency in respect to policy outcomes and in light of governance reforms in recent decades; and social provision.

- **Chapter Six and Seven** are the two discussion chapters of this study. In these two chapters the findings of this study presented in chapter four and five are discussed in the context of the literature/theoretical frameworks presented in chapters two and three. Chapter six addresses the literature and data findings pertaining to the research questions one and two, which surround the concepts of ‘equality’ and ‘efficiency’ in health service provision. While chapter seven discusses the literature and data findings relating to the research questions 3-5 which, through the prism of institutionalism theory, explores the principles of ‘continuity’, ‘institutional stability’ and ‘change’ in the policy trajectory of health care provision.

- **Chapter Eight** provides a summary of the findings presented in the thesis and discusses recommendations for future research in this subject area.

### 1.7 Conclusion.

This thesis is an investigative study of the Irish health care system which examines the ethos of equality present in consecutive health care reforms in terms of: *access* and *entitlement* to health care provision. Furthermore, it also seeks to explore the extent to which *efficiency* in terms policy outcomes and administrative/infrastructural reform has
superseded the instilment of an outright egalitarian ethos in service delivery. In this chapter a brief outline was provided of the background and context of this research, aims and objectives of this study, the core theoretical frameworks utilised in this research and the methodology adapted during the course of investigating and analysing the core research questions of this study.

In the following chapter, literature surrounding the theoretical frameworks of ‘equality’ and ‘efficiency’ will be discussed.
Chapter Two

Conceptualising the principles of ‘equality’ and ‘efficiency’ as determinants in social policy outcomes.

2.1 Introduction
The conceptual principles of ‘equality’ and ‘efficiency’ form a central core in this research in respect to analysing the successive reforms in the Irish health care service. In this chapter, a review of the relevant literature on the theoretical constructs of equality and efficiency is undertaken. Furthermore, this chapter also focuses on the implications in which a principled stance taken by government on equality and efficiency can possess for the delivery of health care provision.

Section 2.2 provides a conceptual overview of the origins of equality in modern society. In this respect, it is put forward that the roots of equality in a modern societal setting are deeply embodied with the expansion of social citizenship rights. Furthermore, the argument explored is that one of the central causes of inequality in modern society relates to a contradiction which exists between maintaining a capitalist system and upholding social equality.

Section 2.3 delves into some of the central philosophical variants of egalitarianism. In particular, this section analyses the theoretical variants of libertarianism, utilitarianism, Liberalism – Rawls theory of social justice, Equality of Capability/Outcome – Sen’s theory of social justice; and the egalitarian perspective of Equality of Condition. Each philosophical position offers a distinctive vision of egalitarianism which can both limit or maximise the level of equality experienced in society.

Section 2.4 explores the distinction which exists between the concepts of ‘equality’ with that of ‘equity’. In this section, it is articulated that equality is an empirical concept whereby emphasis is placed on exploring the distinction or inequality between human persons – i.e. morbidity levels. By contrast, the concept of equity is a normative concept
which has a ‘social justice’ connotation in that the primary focus is on providing ‘equal opportunities’ in health service provision.

Section 2.5 conceptualises the principle of efficiency in health service delivery. Within the confines of this research, the concept of efficiency is defined in the context of the governance structures and principles which oversee the initiation and implementation of health care provision. In this respect, due to its dominant impact on public administrations worldwide and indeed in the Irish context, the theoretical approach of the New Public Management Initiative (NPM) is analysed. As a governance model, the NPM initiative has transformed the thinking of public administration through its innovative principles of strategic management and adaptation of private sector managerial techniques to the public sector where the primary focus is on the ‘outputs’ and ‘outcomes’ produced.

Section 2.6 discusses the impact of the NPM initiative in the Irish context through assessing Ireland’s vision of public service reform in the Strategic Management Initiative. Furthermore, it also explores the significance of the modernisation programme of public service reform on the delivery of principled efficiencies in the Irish health care system through the introduction of strategy statements and also the establishment of the statutory agency, the Health Service Executive.

2.2 Conceptualising the principle of ‘Equality’ in health care provision.

2.2.1 Linking modern interpretations of ‘equality’ to the expansion of universal ‘citizenship’.

From the discussion on equality in chapter 1, section 1.3.1, it is prevalent that a modern conceptualisation of equality cannot be interpreted without reference to the influence and evolution of social citizenship. In the academic writings of R.H. Tawney on egalitarianism and T.H. Marshall on citizenship, social equality in terms of full membership of a community or society has been defined as encompassing three major
dimensions: civil rights; political rights; and social rights. As Sullivan (1998: 74) states, such rights in contemporary society may be defined as follows:

“citizenship rights are those rights concerned with individual liberty and include freedom of speech and thought, the right to own private property and the right to justice; political rights are primarily those rights of participation in the political process of government, either as an elector or as an elected membership of an assembly; social rights cover a whole range of rights, from the right to a modicum of economic security through to the right to share in the heritage and living standards of a civilised society.”

Within this conceptualisation, equality forms a central dimension of citizenship in that the objective of these social rights is to ensure that individuals are treated equally, irrespective of their socio-economic backgrounds. The development of a complete ‘bundle’ of citizenship rights, which is deemed to be the property of all social classes, is a recent phenomenon. For instance, in the eighteenth century, the concept of civil rights, particularly those of equality before the law, were extended to wider sections of the population. In the nineteenth and early twentieth century, political rights limited previously to the ‘aristocratic’ classes were then extended to the middle and working class men and eventually to women. Finally, in the twentieth century we witness through the culmination of the two earlier citizenship rights the emergence of social rights. Previously, social rights were limited to the destitute (i.e. the Poor Laws), however, throughout the twentieth century these rights came to be significantly extended from the initial introduction of selective welfare services towards an eventual creation of a universalist welfare state, for the benefit of the entire population (Sullivan, 1998: 74).

In this sense, it is attributable that Marshall’s argument on the social movement towards political rights – through Chartism, suffragism and enfranchisement (outlined above), led to the extension of equality beyond civil rights. Further to this, the extension of political rights through the election of working class representatives to parliament facilitated the mass campaign for the achievement of equality within the dimension of social rights. These social rights proved to be significant in that they enshrined elements of welfare state policies that emphasised on providing the right to a modicum of economic security through for instance an income maintenance system, the right to a
share in the living standards of a civilised society through policies of full employment and proficient health care services, and finally a right to share a common cultural heritage through the educational system. Thus, this came to be projected as enabling individuals to utilise fully their civil and political rights (Sullivan, 1998: 74-75).

Within this conceptual framework on the creation of equality of rights, there is no intent to create material equality through redistributive social and economic policies. Quite the opposite, Marshall’s theoretical idealism saw equality of social status as a basis of legitimacy for prevailing economic inequalities. The impetus in this context is to uphold the capitalist system and its theoretical core; which allows individuals the freedom to engage in the maximisation of profit through the right to buy, own and sell. Political and social rights in this regard then can be interpreted as being part of an institutional design to maintain the capitalist system and prevent change to the social order. In this context, Marshall’s interpretation of social rights accords community membership for all and as a result makes all individuals stakeholders in the capitalist society without engaging in any fundamental redistribution of income and wealth. Therefore, the motivations of social policy and service provision within the citizenship rights model according to Marshall is to ‘incorporate’ all as members of a societal community and modify the most excessive and debilitating forms of equality whilst legitimising some of the wider and more fundamental inequalities (i.e. in regards to income and wealth) through the process of incorporation (i.e. equality of opportunity in access to education and health discussed below) (Sullivan, 1998: 75).

This line of theoretical reasoning was also given substance in the academic writings of Anthony Crosland (1952 cited in Sullivan, 1998: 75), who articulated that the central aims and objectives of welfare policies in egalitarian terms were not orientated in the direction of equality through income redistribution. In this sense, social equality cannot be attributed as possessing the ultimate purpose of instilling equality through social services. On the contrary, the aim was to provide relief of social distress and the correction of social irregularities. Hence, while inequalities would be inevitably lessened, the creation of equality according the Crosland was a subsidiary objective. According to this stipulation, the welfare state project is presented as an institution
which provides social security and ameliorates excessive inequalities in society rather than instils an outright vision of equality (cited in Sullivan, 1998: 75).

2.3 Defining equality through the theoretical stands of: Libertarianism; Utilitarianism; Liberal Equality; Equality of Capability/Outcome; and Equality of Condition.

The origins of egalitarianism in modern capitalist and industrialist societies can be linked to the development of both citizenship rights and the nation-state itself. However, to contemplate the meaning of equality in a definitional and empirical sense, a more philosophical understanding is necessitated.

In a generic sense, Baker et al., (2004: 21) argue that the ideal of equality can be applied in two mannerisms; between individuals and groups. For instance, they highlight that Article 1 of the Universal Declaration of Human Rights places emphasis on individual equality where it is stated that “All human beings are born free and equal in dignity and rights” (cited in Baker et al., 2004: 21). In addition, there is also the principle of equality being interpreted in respect to groups, such as women and ethnic minorities. At a more fundamental level however, equality as an ideal projects a basic premise that “…all human beings have equal worth and importance and are therefore equally worthy of concern and respect.” (Baker et al., 2004: 23). Within this understanding then, the concept of equality encompasses the principle that every individual deserves some basic level of concern and respect and the placing of some limitation on what it is to treat someone as a human being. Baker et al. suggest that the minimum standards involved in achieving basic equality include; “…prohibitions against inhuman and degrading treatment; protection against blatant violence and at least some commitment to satisfying people’s most basic needs” (2004: 23). However, this ideal of equality cannot capture the inequalities in peoples living conditions or in respect to an individual’s civil rights or educational and economic opportunities. Therefore, due to the basic ideals of equality being somewhat limited to the prevention

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4 A primary example of this was depicted in the creation of the welfare state in Britain during the 1940’s where the social services provided satisfied the citizenship rights based model in that it facilitated universal and full membership of the social community (Sullivan, 1998: 75).
of inhumane treatment, this in turn leads to a demand for more robust egalitarian frameworks as a means of developing a concise understanding of equality through the prism of social justice.

The argument for developing a more robust conceptual framework for interpreting equality in societal terms becomes more apparent when analysing what Turner (1986) depicts as the ‘contradictions’ produced by the capitalist economic system. From the outset, Turner argues that capitalism is a characteristically instable and incoherent social system due to the paradox that exists between ‘equality’ which is essential for its political system and ‘inequality’ which is the foundation of its economic system (1986: 27). This is primarily due to the fact that the modern capitalist system and its market dominance creates an unequal distribution of wealth which comes to be accumulated by owners of property or by those social classes more closely aligned with economic ownership. In this respect, social movements demand a redistribution of wealth via changes in the system of taxation, inheritance and improvements in the standard of living (Turner, 1986: 27).

The contradiction between the generation of wealth under the capitalist system and the political demands for social equality has meant that governments are particularly sensitive to citizens’ demands for the redistribution of wealth and for institutional changes to facilitate educational opportunities as a means of ensuring electoral sustainment. Moreover, governments are also prone to the demands for advancements in health and general welfare. The power of government in responding to these demands resonates in its ability to raise finance – through taxation – as a means of supporting welfare institutions. However, this contradicts or creates tension within the capitalist economic system as it infringes, through governmental taxation, on the profit generated. Highlighting this contradiction and tension within the capitalist societal structure proves to be significant in explaining the various fiscal crisis experienced by governments in upholding the welfare state (Turner, 1986: 27).

In the following subsections, it will be depicted through the divergent theoretical strands of: libertarianism; liberal equality; equality of capability/outcome; and equality of condition; how this contradiction and tension between capitalism and social equality has been addressed within the philosophical confines of egalitarianism.
2.3.1 Libertarian Equality
The philosophical premise of libertarianism embraces a strong endorsement of the ideal of ‘individual rights’. This in turn exclaims that, if everyone is entitled to the goods they possess, a *just distribution* is whatever distribution results from an individual’s ‘free’ exchange of those goods. From this conceptualisation of equality, the only legitimate form of government intervention is to finance ‘background institutions’ that are necessitated to protect the system of free exchange – e.g. policing and the judicial system (Smith, 2009: 2). In this sense, there is a strong emphasis on the principled ideals of *individualism* and *freedom*. The rationale for this conceptualisation comes to be reflected in what Robert Nozick depicts as an entitlement that people have to their ‘natural talents’ and to whatever gains that comes from utilising those talents. Hence, libertarian theorists such as Nozick strongly rule out ‘redistribution’ according to an egalitarian ‘end-state’ premise because this is perceived to violate individual rights and the separateness nature of human persons (Nozick, 1974 cited in Callincos, 2000: 43-44).

2.3.2 Liberal Equality: *A brief critique of the utilitarian egalitarian perspective.*
Under the guise of the utilitarian egalitarian perspective, the primary goal is welfare maximisation; whereby welfare (or utility) is identified with pleasurable mental states. Thus, emphasis is placed on the satisfaction of a person’s preferences for some states of affairs over others. Individuals in this context are perceived to be ‘rational choosers’ who in having ordered their preferences, pursue to maximise their welfare in accordance with these defined preferences. As such, utilitarianism adjudicates actions on the basis of their consequences in the sense that the object is to achieve those outcomes that return the greatest sum of satisfaction for society at large (Callinios, 2000: 42). In this sense, a ‘just society’ is presented as one in which the major institutions are organised in a manner that yields the greatest net balance of satisfaction summed across all individuals within that society (Smith, 2009: 2). The logic of the utilitarian perspective is summated by Jeremy Bentham where he highlights the egalitarian spirit through the axiom “everybody to count for one, nobody for more than one” (Mill and Bentham, 1987 cited in Callinicos, 2000: 42). However, this goal of welfare maximisation cannot be construed as an attempt to instil equal distribution of income and wealth. As
Callinicos points out, if in the event of there being some highly unequal distribution, whereby the satisfaction of the rich outweighs the dissatisfaction of the poor and where the sum of satisfied preferences is greater than what would be delivered through a more egalitarian distribution, then utilitarian’s would have no reason to reject that outcome (2000: 43).

The utilitarian perspective may also generate ‘highly illiberal consequences’ in the sense that the general welfare of society could be increased at the expense of individual members of society. For Rawls, the utilitarian theoretical perspective represents the extension to society a model of individual choice; ‘just as it is rational for one man to maximise the fulfilment of his system of desires, it is right for society to maximise the net balance of satisfaction taken over by all its members’ (cited in Callinicos, 2000: 43). As such, the utilitarian approach to social choice involves the “conflating of all persons into one”, which by extension infers that distinctions between persons are not recognised (Callinicos, 2000: 43).

This characterisation of the utilitarian perspective represents the point of departure for those within liberal philosophical thought. Essentially, the utilitarianism perspective is thought to violate individual liberty. As Kant denotes, individual liberties become infringed due to the fact that the net sum of societal satisfaction can leave some individuals goals unfulfilled – e.g. the poor – which implies that people are treated only as a ‘means’ and not as an ‘end’ in the process of welfare maximisation (cited in Callinicos, 2000: 43). Thus, liberal philosophers have sought to derive a theory of equality based fundamentally on the preservation of individual rights. For instance, Nozick argues that these rights should be recognised as ‘side-constraints’ which have the effect of offering individuals moral protection against social action. In the sense that “they (individuals) may not be sacrificed or used for the achieving of other ends without their consent…Side-constraints express the inviolability of other persons” (Nozick, 1974 cited in Callinicos, 2000: 43-44). However, by contrast, Rawls criticism of utilitarianism, and his extension to Kant’s theoretical criticism of this school of thought, leads to the unique creation of an egalitarian theory of justice. From this standpoint, Rawls develops a theory in which individual rights are not conceived as a constraint on collective action.
but rather are perceived as the consequence of a requirement within a ‘just social order’ (Callincos, 2000: 44).

In observing the empirical practice of utilitarianism, Sen (1992) argues that as a theoretical approach its method of measuring individual utility in terms of some definition of mental characteristics such as pleasure, happiness or desire prove to be restrictive in taking into account individual advantage. This occurs in two distinct mannerisms; (a) it ignores freedoms and focuses solely on achievements; (b) it ignores achievements other than those measured in one of these mental metrics. In this sense, despite the fact that utility is meant to represent individual well-being, it provides a restrictive account of that and fails to emphasise on the freedom to pursue well-being. This proves to be particularly encumbering in respect to entrenched inequalities. Sen argues, in the event of persistent adversity and deprivation, the victims may not respond through grieving and grumbling continuously, and may even reject the premise of desiring a radical change of circumstances. Rather, it is perhaps more logical to believe that an individual would appreciate small breaks and not engage in pinning for the impossible and improbable. Therefore, applying a mental metric of desire and fulfilment in accordance with a pleasure-pain calculus may be misleading. This rests on the premise that the extent of an individual’s deprivation may be substantially ‘muffled’ in the utility metric (Sen, 1992: 6-7). As a consequence, the misleading nature of utility metrics may be particularly significant in the context of assessing inequalities in health care provision.

2.3.3 Rawls derivation of an egalitarian theory of justice.

2.3.4 Social Contract: conceptualising the ‘original position’ and the ‘veil of ignorance’ in Rawls theoretical framework.

Rawls egalitarian theory of social justice has proven to dominate this field of thought due to the fact that later theorists have defined their theories in opposition to this framework (Kymlicka, 2002: 55). The construction of Rawl’s theory of equality and social justice arose in response to the utilitarian perspective. It is prevalent from the conceptualisation of utilitarianism above that Rawls, in establishing an egalitarian
theory of justice, sought to rehabilitate the social contract idealisms of Locke, Rousseau and Kant. In this respect, Rawls principles of justice are reminiscent of those that an individual would chose within a hypothetical *original position*. The ‘original position’ consists of parties which are conceived to be rational actors whereby they order their preferences and in the process seek an outcome that maximises their welfare as determined by those preferences. Furthermore, the parties in this process must choose their preference behind a *veil of ignorance* (Callinicos, 2000: 44). As Rawls states;

“Among the essential features of this situation is that no one knows his place in society, his class position or social status, nor does anyone know his fortune in the distribution of natural assets and abilities, his intelligence, strength and the like. I shall even assume that the parties do not know their conceptions of the good or their special psychological propensities. The principles of justice are chosen behind a veil of ignorance. This ensures that no one is advantaged or disadvantaged in the choice of principles by the outcome of natural chance or the contingency of social circumstances. Since all are similarly situated and no one is able to design principles to favour his particular condition, the principles of justice are the result of fair agreement or bargain.” (1971: 12).

Hence, the ‘veil of ignorance’ represents an intuitive test of fairness; in that it ensures that those who may be able to influence the selection process in their favour, due to their better socio-economic position, are unable to do so. Thus in sum, the ‘original position’ is symbolic of equality between human beings as moral persons (Kymlicka, 2002: 63).

In terms of depicting how the principles of justice are chosen, the foundational idealism to this is that while no individual knows what position they hold in society, or what goals they will have, there are certain things that are wanted or needed to enable an individual to lead a good life. Regardless of the disparities between individuals’ plans in life, they all share one thing in common – which is they involve leading a life and a commitment to a good life. Within Rawls (1971: 62) theory, these elements are called ‘primary goods’. There are two kinds of primary goods;

1. Social primary goods: rights and liberties; powers and opportunities; income and wealth – those goods which are directly allocated by social institutions.
2. Natural primary goods: health and vigour; intelligence and imagination – those goods which are influenced by the basic institutional structure but are not directly under its control.

According to this definition then, people behind the ‘veil of ignorance’ seek to ensure that they will have the best possible access to those primary goods distributed by prevailing social institutions. Furthermore, due to the premise that no one knows what position they will occupy (due to people inevitably deciding what is best for them), individuals automatically choose what is best for everyone impartially. Thus, persons in the ‘original position’ are attempting to ensure the best possible access to the primary goods which enable them to lead a good life, without in the process knowing what position they will end up in society (Kymlicka, 2002: 65). In this sense, Rawls argues that we in effect hold society responsible for the fair share of primary social goods. Whilst individuals are responsible for selecting their own ‘ends’ under an expectation that they have a reasonable chance of satisfying them within just arrangements (1982 cited in Daniels, 1985: 38). As such, the just arrangements are designed to ensure that individuals are guaranteed a fair share of certain basic social primary goods (Daniels, 1985: 38).

2.3.5 Conceptualising Rawls principles of justice.

In presenting Rawls egalitarian theory of justice, it is important to note that his conceptualisation consists of one central idea which is that “all social primary goods – liberty and opportunity, income and wealth and the basis of self-respect – are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favoured in society” (Rawls, 1971: 303). Therefore, within this ‘general conception’ Rawls regards the ideal of justice to mean the granting of an equal share of social goods to all. However, as Kymlicka argues, there is a significant ‘twist’ in Rawls theory which is that he does not treat people as equals by removing all inequalities in their entirety, only those which have the effect of disadvantaging persons. As such, it can be argued that Rawls theory of social justice permits inequalities to
prevail if they serve to improve a person’s initial share of social primary goods and prohibited if they invade a person’s fair share. Thus, if certain inequalities benefit everyone, through drawing out socially useful talents and energies, then they are depicted as acceptable (Kymlicka, 2002: 55). Rawls depicts this element of his egalitarian construction of social justice as granting the least well off a kind of veto over inequalities; in which they would exercise their right to reject inequalities that sacrifice rather than promote their interests (Rawls, 1978: 64 cited in Kymlicka, 2002: 55). However, there is a sense of conflict in the theory in that this form of redistribution only favours the least well off in one way; which is through their ‘income’ and not their ‘liberty’ (Kymlicka, 2002: 55).

In terms of evaluating this derivation and the sense of conflict further, Rawls solution was to break down the general conception into three distinct parts, which are arranged in accordance with the principle of ‘lexical priority’. As Rawls states;

“First Principle – Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.
Second Principle – Social and economic inequalities are to be arranged so that they are both:
(a) to the greatest benefit of the least advantaged, and
(b) attached to the offices and positions open to all under conditions of fair equality of opportunity.

First Priority Rule (The Priority of Liberty) – The principles of justice are to be ranked in lexical order and therefore liberty can be restricted only for the sake of liberty.
Second Priority Rule (The Priority of Justice over Efficiency and Welfare) – The second principle of justice is lexically prior to the principle of efficiency and to that of maximizing the sum of advantages; and fair opportunity is prior to the difference principle.” (1971: 302-3).

These principles form the ‘special conception’ of justice and provide systematic guidance to understanding Rawls conception of egalitarian theory of social justice. In addition, these principles illustrate that some social goods are more important than others and cannot be sacrificed as a means of improvement to other goods. As such, the principles dictate that equal liberties take precedence over equal opportunities which take precedence over equal resources. Within each categorised principle above however
one central concept remains, *an inequality is only allowed if it benefits the least well off in its entirety.*

Callinicos (2000: 46-47) argues that the second principle, the ‘difference principle’, forms a central core in his theory of justice. From this understanding;

“...the difference principle represents, in effect, an agreement to regard the distribution of natural talents as a common asset and to share in the benefits of the distribution whatever it turns out to be. Those who have been favoured by nature, whoever they are, may gain from their good fortune only on terms that improve the situation of those who have lost out. The naturally advantaged are not to gain merely because they are more gifted, but only to cover the costs of training and education and for using their endowments in ways that help the least fortunate as well. No one deserves his greater natural capacity nor merits a more favourable starting point in society. But it does not follow that one should eliminate these distinctions. There is another way to deal with them. The basic structure can be arranged so that these contingencies work for the benefit of the least fortunate. …” (Rawls, 1971: 101-102).

From this conceptualisation then, the second principle is developed in favour of equality. Where inequalities in effect, require justification by way of how they benefit the least well off in society. Moreover, an individual’s initial endowments of natural assets and the contingencies of their growth and nurture in early life are illogical from a moral point of view. This rests on the premise that the ‘veil of ignorance’ conceals from individuals to the original position how they have fared in a given distribution (Callinicos, 2000: 47).

2.3.6 Liberal conception of: equality of opportunity.

Within the liberal philosophical school of thought, there has been a tendency to rely on a *procedural* notion of equality of opportunity as a means of justifying a system in which unequal outcomes are conceived to be normally acceptable (Daniels, 1985: 39). In this sense, inequalities of income and prestige are assumed to be justified only in the event of there being fair competition in the awarding of the offices and positions which yield such benefits (Kymlicka, 2002: 57). As such, it is perceived as morally justifiable that there are ‘winners’ and ‘losers’, even in the event of accumulating important social goods, provided that the process is *fair* to all participants. More specifically, the essence
of fairness in equality of opportunity comes to fruition through ensuring that certain morally irrelevant features of individuals such as; race, religion, ethnic origin and sex do not act as a deterrent to people being selected in the competition for positions. Rather, a person’s talents and skills should be seen as the predominant determinant for the process of selection and reward (Daniels, 1985: 39-40). Hence, equality of opportunity is perceived as fair due to it ensuring that an individual’s ‘fate’ is determined by their choices rather than their circumstances.

As a theoretical construct, the principle of equality of opportunity has proven to be controversial within the liberal philosophical school of thought. The central reason for this rests on the simplicity with which it determines outcomes for individuals; in the sense that with success being ‘merited’ and going to those who ‘deserve’ it, there is an element of ignorance to other significant factors. For instance, it fails to account for the irreducible differences in natural talents and skills between individuals which in turn make the opportunity greater for some in competitive situations (Daniels, 1985: 40; Kymlicka, 2002: 58). Additionally, it fails to efficiently theorise ‘natural’ inequalities between persons and the effects which this has on their ‘opportunity’, as Kymlicka, 2002: 59 argues;

“The prevailing view suggests that removing social inequalities gives each person an equal opportunity to acquire social benefits, and hence suggests that any differences in income between individuals are earned, the product of people’s effort or choices. But the naturally handicapped do not have an equal opportunity to acquire social benefits, and their lack of success has nothing to do with their choices or effort. If we are generally interested in removing undeserved inequalities, then the prevailing view of equality of opportunity is inadequate.”

This controversial element also conflicts with Rawls theory, In turn, this led to Rawls derivation of the ‘difference principle’, discussed above, which denotes that people who are talented do not automatically deserve their advantages or to a greater share of society’s resources. Rather, their higher expectations are only just if they operate as part of a scheme that improves the expectations of the least advantaged in society (Rawls, 1971: 75). This is a transitioned elevation from a ‘formal’ interpretation of equality of opportunity whereby it is construed as a negative constraint that requires
society to refrain from imposing specific barriers to equal opportunity – such as ethnic discrimination – to a positive obligation which corrects all the influences which interfere with equality of opportunity. In this context, a positive obligation sets as its goal through social programs to correct elements of competitive disadvantage – such as underdevelopment of talents and skills or consequences which have arose from experiences of racists or sexist practices or as effects of a poor family background. This positive conception then is reflective of what is called fair equality of opportunity (Daniels, 1985: 41).

2.3.7 Extending Rawls theory of justice to health care: instilling the principle of ‘fair’ equality of opportunity.

As Daniels (1985: 45) points out, extending Rawls theory of fair equality of opportunity to health care is quite significant because meeting health care needs – through its administrative institutions – has a profound effect on the distribution of opportunities. Thus, health care institutions can be made subject to regulation under the fair equality of opportunity principle. Furthermore, through acknowledging the unique connection between normal human functioning with the opportunity range open to individuals, the compatibility of extending Rawls theory of justice to health care becomes apparent.

In a similar vein to correcting unfair disadvantage – in natural talents, socio-economic background or educational attainment – it is perceived as equally important to utilise resources in countering the natural disadvantages incurred by disease. However, this does not entail a systematic levelling of the playing field where natural inequalities are concerned. Rather, it sets out as its principle goal, the achievement of ‘normal functioning’; whereby it concentrates on a specific set of obvious disadvantages and aims to eliminate them. In many ways, this approach bears significant commonalities between health care and education as these institutions also operate as contributors through ensuring fair equality of opportunity where individual needs are not equally distributed. As various social factors such as race, socio-economic class and family background may produce an unequal distribution of social goods and disadvantages that in turn requires the education system to provide for ‘special learning needs’. Thus, this
entails that fair equality of opportunity applies as a means of ensuring that those needs are met (Daniels, 1985: 46).

In returning to Rawls theorisation of the ‘original position’ and the index of ‘primary goods’, the moral justification for subsuming health care institutions under the fair opportunity principle facilitates the preservation of the system as close as possible to the original idealism within which Rawls theory was founded namely; that we are concerned with normal, fully functioning persons with a complete lifespan. Hence, the establishment of preventative health care institutions in this context can be depicted as a first defence of this idealisation in that they are designed to minimise the possibility of departure from the ‘normality’ assumption (Daniels, 1985: 47). However, not all departures from normal functioning can be prevented. In that, a second tier of institutions are necessitated to correct departure from this idealisation. As Daniels (1985: 48) argues;

“...These institutions deliver personal medical and rehabilitative services that restore normal functioning. Similarly, not all treatments are cures, and some institutions and services are needed to maintain persons in a way that is as close as possible to the idealisation. This third layer of institutions is involved with more extended medical and social support services for the (moderately) chronically ill and disabled and the frail elderly. Finally, a fourth layer involves health care and related social services for those who can in no way be brought closer to the idealisation. Terminal care and care for the seriously mentally and physically disabled fit here, but they raise serious issues which may not just be issues of justice. Indeed, by the time we go to the fourth layer moral virtues other than justice become prominent.”

From this conceptualisation, each of the four levels of health care institutions attempts to correct in a specific fashion a departure from the Rawlsian idealisation that all persons are enabled to be normal functioning. As such, it is preferable to ‘prevent’ rather than to have to ‘cure’; and to cure rather than to have to compensate for loss of normal functioning. However, it is at the fourth level, which concerns the permanently

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5 Institutions of health care in this context include public health, environmental cleanliness, preventive personal medical services, occupational health and safety, food and drug protection, nutrition and education, and educational and incentive measures to promote individual responsibility for healthy lifestyles (Daniels, 1985: 48).
disabled, where it is perceived that it is no longer possible to protect opportunities and uphold justice (Daniels, 1985: 48).

Through maintaining the object of normal functioning, health care institutions sustain an individual’s fair share of the normal range of opportunities – or plans in life – that an individual would choose within a given societal context. Additionally, an individual’s fair share of that normal opportunity range are in effect those plans of life that would be made were they not ill or disabled or were they suitably protected against underdevelopment following unfair social practices and the consequences of social inequalities (Daniels, 2001: 3).

Therefore, the idealisation of normal functioning through health care institutions is to ensure that individuals can continue to participate in the political, social and economic life of their society. Effectively, it also sustains them as fully participant citizens – as normal collaborators and competitors – in all spheres of social life. From this conceptual definition of normal functioning, it is evident that the relationship between health care and the protection of opportunity suggest that the appropriate principle of distributive justice in articulating a regulatory design of a health care system; is the ethical premise of protecting equality of opportunity. The central reason for this rests on the fact that the premise not only prohibits discriminatory barriers to access, it also requires ‘positive’ social measures that ‘correct’ negative effects on opportunity – such as socio-economic inequalities (Daniels, 2001: 3).

Thus, Daniels theorisation of health care in the context of Rawls theory of justice is compatible. As for Rawls (1971), the primary focus was not on the seeking of a determination of what we owe each other by measuring our satisfaction or welfare but rather through measuring our well-being through publicly accessible measures. Rawls interpreted this through the index of primary social goods (discussed above section 2.3.4) which include rights and liberties, power and opportunity, income and wealth and the social basis of self-respect. In extending this to health care, Daniels included the protection of ‘normal functioning’ within the scale of the primary goods of opportunity. This is consistent with Rawls theorisation, in that it sets out to assist others (the least-advantaged) in meeting health care needs (Daniels, 2001: 4).
In terms of the impact of this institutional design for health care institutions and for matters of resource allocation; Daniels argues that it has some significant implications. The most significant is that it supports the provision of universal access to appropriate health care – which includes both traditional public health and preventative measures – through public or a mixed public and private system of insurance. Additionally, health care, which is aimed at protecting *fair* equality of opportunity, should not be distributed according to the principle of *ability to pay* (Daniels, 2001: 4).

2.3.8 Theoretically conceptualising Sen’s – *Equality of Capability/Outcome*. 
In deriving a theoretical conception of equality, Sen has postulated that two central issues come to the fore; (1) Why equality? (2) Equality of what? Both questions, he argues are distinct yet they are also significantly interdependent (1992: 12). From this postulation, he argues that the idea of equality is confronted by two distinguishing types of diversification; (1) the basic heterogeneity of human beings, and (2) the multiplicity of variables through which equality can be judged. It is from this complex confrontation of diversity that leads to Sen’s derivation of a central question; ‘Equality of what? Furthermore, in analysing the diversification and relationship between these two variables, Sen derives his theorisation of ‘equality of capability’ (Sen, 1992: 1).

2.3.9 The ideals of ‘Human diversity’ within Sen’s egalitarian theorisation. 
Sen’s conceptual theory places significant emphasis on the ideal of human diversification and the implication which this has in assessing equality in terms of the different variables. In respect to human diversity he states that;

“We differ from each other not only in external characteristics (e.g. in inherited fortunes, in the natural and social environment in which we live), but also in our personal characteristics (e.g. age, sex, proneness to illness, physical and mental abilities).” (Sen, 1992: 1).

With such diversification, the external environment and personal circumstance can have a significant impact on an individual’s well-being and capability to function. In relation to the social environment, the make-up of societies and communities can offer different opportunities dictating what we can or cannot do – epidemiological factors in a
region a person lives can have a profound effect on health and well-being. Similarly, the differences in personal characteristics and experiences can raise significant issues in assessing inequality. In this context, acquiring an equal income can still leave much inequality in our ability to do what one would value doing. For instance, a disabled person cannot function in the same manner as an able-bodied person, despite both having exactly the same income (Sen, 1992: 20).

As such, there is a demand for a substantive egalitarian framework which recognises the existence of pervasive human diversity. Up until this point, it is argued that distinct theoretical variants of egalitarianism have tended to seek equality in one dimension; for instance Libertarians demand equality of rights and liberties, Utilitarian’s assign equal weights to everyone’s utility, Rawls theory of social justice advocated for equal liberty and the equal distribution of social primary goods (Smith, 2009: 2). To achieve equality in all dimensions, it can be construed that if people experienced the same level of equality in one social space (e.g. incomes) this would lead to the experience of equality in other social spaces (e.g. health, well-being, happiness). However, as a consequence of ‘human diversity’ equality in one space tends to go with an inequality in another (Sen, 1992: 20). As Sen states;

“Equality is judged by comparing some particular aspect of a person (such as income, or wealth, or happiness, or liberty or opportunities, or rights, or need-fulfilments) with the same aspect of another person. Thus, the judgement and measurement of inequality is thoroughly dependent on the choice of the variable (income, wealth, happiness, etc.) in terms of which comparisons are made. I shall call it the ‘focal’ variable – the variable on which the analysis focuses, in comparing different people”. (Sen, 1992: 2).

From this standpoint, the most important element to the development of an egalitarian theoretical framework is to secure consensus on the space within which equality is required. Hence, this leads to Sen’s (1992) significant question; ‘Equality of what?’
2.3.10 Interpreting the concepts of ‘freedom’ and ‘achievement’ in Sen’s theorisation.

In comparison to the theories of equality and justice discussed above, Sen’s theorisation differs significantly when offering his interpretation of the concepts of freedom and the ability to achieve resources. In this context, Sen (1992: 31) argues that the central reasoning for this rests on the premise that;

“[a] person’s position in a societal arrangement can be judged in two different perspectives, viz. (1) the actual achievement, and (2) the freedom to achieve. Achievement is concerned with what we manage to accomplish, and freedom with the real opportunity that we have to accomplish with that value. The two need to be congruent.”

As such, inequality is viewed in respect to an individual’s achievement or actual freedoms to achieve. Significant emphasis is placed on conceptualising the distinction between achievement and freedom. Therefore, conceptualising ‘achievement’ proves to be a central precursor in assessing inequalities within a given space. There are numerous ways in which ‘achievement’ can be analysed – for instance through utility (e.g. pleasures achieved or desires fulfilled), or through opulence (e.g. incomes earned or consumptions enjoyed) or through quality of life elements (e.g. measures of living standards). The most significant issue in characterising the concept of ‘achievement’ is the distinction between the extent of achievement and the freedom to achieve (Sen, 1992: 31).

The theories of social justice presented thus far proved to be significant in shaping the egalitarian perspective. This is particularly relevant when taking into consideration the distinguished approaches adopted in respect to ‘human diversity’, ‘freedom’ and ‘achievement’. For example, in regards to the Rawlsian conception of equality and theory of justice, the construction of the ‘primary goods’ and the ‘difference principle’, it is argued that the theoretical construct neglects the fundamental diversity of human beings. If one considers two persons holding the same bundles of primary goods, these individuals can nonetheless have very different freedoms to pursue/achieve their perceptions of the good (Sen, 1992: 8). Hence, there is a distinctive relationship between ‘primary goods’ and ‘freedom’ and/or ‘well-being’ as both can
vary with interpersonal (e.g. abilities, predispositions, physical differences) and intergroup (e.g. socio-economic class, gender of men and women) variations of specific characteristics (Sen, 1992: 27).

The distinction between ‘primary goods’ and ‘freedom’, leads us to a contemplation of how ‘achievement’ is actually pursued within Rawls theorisation. As Sen (1992: 33) states;

“Since the means in the form of resources, primary goods, etc., undoubtedly enhance the freedom to achieve (other things remaining the same), it is not unreasonable to think of these moves as taking us towards freedom – away from attention being confined exclusively to evaluating achievement.”

Therefore, when attempting to achieve equality in the allocation of primary goods, this has within egalitarian theory led to a shift in the evaluative focus towards the assessment of ‘freedom’ (e.g. liberty) rather than what is actually ‘achieved’ (e.g. well-being). Thus, the emphasis appears to be on the means to achieve freedom rather than on what is actually achieved. The significance of this rests on the fact that the holdings of primary goods cannot reflect the substantive freedoms enjoyed by different persons. This is based on the premise that there can be important variations in the ‘conversion’ of primary goods into freedoms. Such problems can include the complexities and intricacies associated with intragroup relations and interactions. However, variations in conversion can also arise from the simple physical differences between persons. As Sen (1992: 33) states;

“…a poor person’s freedom from undernourishment would depend not only on her resources and primary goods (e.g. through the influence of income on the ability to buy food), but also on her metabolic rates, gender, pregnancy, climatic environment, exposure to parasitic diseases and so on. Of two persons with identical incomes and other primary goods and resources (as characterized in the Rawlsian or Dworkinian frameworks), one may be entirely free to avoid undernourishment and the other not at all free to achieve this.”

In a similar essence to Sen’s criticism of Rawls egalitarian theory of the ‘difference principle’ and ‘primary goods’, the theoretical ideal of ‘equality of
opportunity’ is also depicted as restrictive when interpreted in the context of ‘actual achievement’ and ‘the freedom to achieve’. While the principle of equality of opportunity depicts a person’s capability to pursue his or her objectives, it is somewhat limited due to its restrictive focus on “equal availability of some particular means, or with reference to equal applicability (or equal non-applicability) of some specific barriers or constraints” (Sen, 1992: 7). Therefore, as a principle, it cannot be attributed as being symbolic of equality of overall freedoms. This is due to the diversity of human beings and more significantly the existence and importance of the various means (e.g. income or wealth) that do not fall within the remit of the defined equality of opportunity. However, Sen argues that the ideal of equality of ‘capabilities’ or ‘achievements’ proves to be a more robust way of considering ‘real’ equality of opportunities in the eliminating of unambiguous inequalities (1992: 7). Thus, it can be attributed that the primary emphasis of Sen’s theoretical perspective is to assess the achievements through the perspective of equality of capability or outcome.

2.3.11 Conceptualising Sen’s principles of egalitarianism.

One of the fundamental cornerstones to Sen’s theory of equality is his exploration of the ‘capability’ perspective and its concurrent assessment of ‘well-being’ and the ‘freedom to pursue well-being’. This theoretical construct is conceptualised in terms of the ‘functionings’ which make-up the well-being/achievement of persons, as Sen (1992: 39) states;

“The well-being of a person can be seen in terms of the quality (the ‘well-ness’, as it were) of the person’s being. Living may be seen as consisting of a set of interrelated ‘functionings’, consisting of beings and doings. A person’s achievement in this respect can be seen as the vector of his or her functionings. The relevant functionings can vary from such elementary things as being adequately nourished, being in good health, avoiding escapable morbidity and premature mortality, etc., to more complex achievements such as being happy, having self-respect, taking part in the life of the community, and so on. The claim is that functionings are constitutive of a person’s being, and an evaluation of well-being has to take the form of an assessment of these constituent elements.”

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A concept related to the theoretical notion of functionings is that of the ‘capability’ to function. This represents the various combinations of functionings – beings and doings – that a person can achieve. As such, capability represents a set of vectors of functionings, encompassing a person’s freedom to lead one type of life or another. Sen argues that the relevance of a person’s capability to his or her well-being relates to two distinct yet interrelated considerations. Firstly, if the conceptual ideal of achieved functionings are representative of a person’s well-being, then the capability to achieve functionings (e.g. all the alternative combinations of functionings a person can choose to have) will be constitutive of a person’s ‘freedom’ – the real opportunities – to possess well-being. Hence, importance is attached to the freedoms that different people respectively enjoy to achieve well-being (Sen, 1992: 40).

In the second instance, the connectedness between well-being and capability has the effect of making ‘achieved’ well-being depend on the ‘capability’ to function. Choosing is depicted as a valuable part of living a life whereby the genuine choices and options are perceived to be much richer. The capability set, in this instance can give information on the varieties of functioning vectors that are in reach of a person. Therefore, this is in contrast to the Rawlsian ‘primary goods’ and ‘fair equality of opportunity’ perspectives which are perceived to focus on the *instruments* of achieving well-being and other objectives that are in effect representative of the *means* to freedom. This is based on the premise that the ‘functionings’ belong to the constitutive elements of well-being and the ‘capability’ represents the freedom to pursue these constitutive elements. Furthermore, capability may also have a direct role in contributing to well-being itself insofar as it can facilitate decisions or choosing parts of living. Thus, capability concentrates directly on the ‘freedom’ rather than on the ‘means’ to achieve freedom, it in sum identifies the *real* alternatives people have. As such, it is representative of a more substantive form of freedom. This symbolises that while the functionings are reflective of well-being; capabilities are reflective of a person’s freedom to achieve well-being (Sen, 1992: 42, 49).
2.3.12 Conceptualising the theory of ‘Equality of Condition’.

Baker et al (2004) theory, equality of condition, extends beyond the liberal egalitarian assumption that many major inequalities are inevitable and that the task for society is to make them fair. On the contrary, this egalitarian framework sets out a more ambitious intent, which is to eliminate major inequalities in their entirety or to at least dramatically reduce the current scale of inequality in society. At a fundamental level, this theoretical approach to inequality is deeply rooted in the changing and changeable social structures and more specifically in structures of ‘domination’ and ‘oppression’. In this context, evaluation of social structures hold a significant cornerstone in this theory as they create and continually reproduce the inequalities that liberal egalitarians foresee as an inevitable social consequence. Equality of condition theorists argue that these social structures can indeed be changed into the future, as they have been in times past. In terms of analysing the types of social structures that exists, Baker et al. (2004: 33) focus on;

“…capitalism (a predominantly market-based economy in which the means of production are privately owned and controlled), patriarchy (systems of gender relationships that privilege men over women) and racism (social systems that divide people into ‘races’ and privilege some races over others) and other systems of oppression.”

Whilst the liberal egalitarians (e.g. Rawls – primary social goods) place emphasis on the ‘rights’ and ‘advantages’ of individuals, the equality of condition theorists focus tends to be on the rights and advantages of groups. Another point of contrast between these two theoretical schools of thought rests on the premise that while liberal egalitarians tend to focus on how things are distributed in society, the equality of condition theorists tend to concentrate on how people are related, particularly through power relations. Moreover, the equality of condition egalitarian perspective has a tendency to emphasise on the influence of social factors on people’s choices and decisions in contrast to the liberal egalitarian’s idealism of treating individuals as being responsible for their success and failures.

Although the theory of equality of condition favours an ideal of people having a wide array of choices, they also emphasise on the concept of ‘opportunities’ in a
stronger sense. The liberal egalitarian conceptualisation implies ‘fairness’ in the competition for advantage; whereby the ‘opportunity’ is the right to compete and not the right to choose among alternatives of similar worth. This is in distinction to the equality of condition idealism which focusses on enabling and empowering people to exercise what has been described as “real choices among real options” (Baker et al., 2004: 34).

As such, Baker et al., (2004) highlight that these opportunities of real choices and options through five dimensions of equality. In the first dimension of ‘respect and recognition’, they stipulate equality through the importance of having the freedom to live in one’s life without the burden of contempt and enmity from the dominant culture. Within the second dimension, ‘equality and resources’, they highlight the significance of having wide resource-dependent options which is of roughly the same values as those of others. In the third dimension, ‘love, care and solidarity’, they interpret an egalitarian premise that promotes circumstances in which people have ample scope for forming valuable human attachments. The third dimension, ‘power’, stresses the importance of enabling individuals to equally influence decisions which affect their lives. In the final dimension, ‘working and learning’, the theoretical ideal of equality of condition refers to enabling individuals to develop their ‘talents’ and ‘abilities’ and that everyone has a ‘real choice’ among occupations which they find satisfying and fulfilling (Baker et al., 2004: 34). From the above conceptualisation of this theoretical perspective, in a similar vein to Sen’s theory, equality of capabilities/outcomes, there is an evident trajectory towards providing persons with real choices and real outcomes.

2.4 Distinguishing between the concepts of ‘Equality’ and ‘Equity’ in health service provision.

In conceptualising a philosophical understanding of egalitarianism in the health care arena, a distinction exists between the principles of ‘equality’ and ‘equity’ in social provision. When analysing the practice to health care provision, the concepts of ‘equity’ and ‘equality’ are often utilised interchangeably without due consideration for their meanings. In respect to policy implementation, Northway (2011) argues that misunderstandings surrounding the conceptual terminology can have the effect of leading to inappropriate interventions whereby practitioners believe that they may doing
the right thing without realising that their decision may be compounding a specific health care problem. Therefore, if equity or equality is the desired stated goals in health care policy, it is imperative to have clarity in relation to the meaning and purpose of both terms.

In the context of equity, Whitehead (1990: 7) provides the following definitions;

“Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided.”

“Equity is therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible.”

As such, Whitehead argues that the object of policy within an equity framework is not to eliminate all health differences to ensure that everyone has the same level and quality of health. On the contrary, the primary aim is to reduce or eliminate ‘differences’ deemed to result from elements that are considered to be ‘avoidable’ and ‘unfair’ (Whitehead, 1990: 7).

In practice, Whitehead’s (1990: 8-10) definition of equity concerns three dimensions;

- Equal access to achievable care for equal need – this implies equal entitlement to available services for all, a fair distribution of health care throughout the country based on the health care needs and ease of access in each geographical area and the removal of other barriers to access.
- Equal utilisation for equal need – In this regard, it is emphasised that if differences are found in the rates of utilisation of certain services by different groups, this does not systematically mean that these differences are inequitable. On the contrary, it is an indication that further study and analysis is required to ascertain why utilisation rates are different. However, where the use of services is restricted by social or economic disadvantage, then there is a case for aiming for equal utilisation rates for equal need.
Equal quality of care for everyone – this implies that providers will strive to provide the same level of high standard professional care for all sections of the community.

Braveman and Gruskin (2003: 254) define equity in health care;

“...as the absence of systematic disparities in health (or major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic or religious group) at further disadvantage with respect to their health; health is essential to well-being and to overcoming other effects of social disadvantage.”

As such, equity in health care means ‘social justice’ or ‘fairness’. Thus, its primary purview is to remove socially unjust or unfair health disparities (Braveman and Gruskin, 2003: 254). However, the practical meaning of equity in health care remains ambiguous due to there being no clear agreement as to what inequalities are unnecessary, avoidable, unfair and unjust and as a consequence inequitable (Chang, 2002: 488, 490).

In terms of differentiating the distinction between ‘equality’ and ‘equity’ in health care, Chang (2002: 488) argues that equity is a normative concept while equality is an empirical concept. This distinction becomes clearer when assessing approaches/responses to ‘inequalities’ and ‘inequities’. For instance, when assessing equality in an empirical context, this involves the design of a valid and reliable instrument to test and/or measure any differences or ‘inequalities’ in ‘health status’ that may exist between various individuals or groups. However, to ascertain inequalities as ‘inequities’, a normative appraisal system is required (Chang, 2002: 488). The most common amongst such appraisals is a biological one which involves evaluating issues such as;

“Are there any biological differences that may explain the observed variations in health status? If no plausible biological differences can be found then, it is probable that variations in health status
are caused by (physical and social) environmental factors, and hence are more amenable to human intervention.” (Chang, 2002: 488).

Hence, the distinction between equality and equity can be derived in respect to the divergence that exists between the conceptual meaning of ‘inequalities’ and ‘inequities’. From the quotation above, the focal point of equity is concerned with the unethical distribution of resources and other processes that drive a particular inequality between advantaged and disadvantaged groups in an unjust or unfair manner – e.g. differences in nutritional status or immunisation levels between boys and girls; racial/ethnic differences in the likelihood of receiving appropriate treatment for a heart attack (Braveman and Gruskin, 2003: 255). While equality, in an ‘empirical’ sense, engages with assessing health status, its determinants and their modifiability (Chang, 2002: 489).

In terms of conceptualising the impact which ‘equity’ has on shaping the overall organisation of health care, Chang (2002: 489) points out that equity appraisals need to be ‘broad based’ where it would be concerned with;

“… (a) the distribution of health (the end) as well as of opportunities (the means) to achieve optimal health; (b) meeting health and health care needs equitably, through a health care insurance scheme and a formal health care system; (c) applying the principle of distributive justice to all aspects of health care, including financing, funding, access, responsiveness, and quality; and (d) the macro-management and micro-management and decision making of the health care system. It is well known for many decades that determinants of health are multifactorial, encompassing human biology, environment, lifestyle, and health care organisation; hence authority and responsibility for improving health are also widely dispersed to individuals and organisations at all levels and in all sectors.”

The framework for appraising equity in health care is denoted in Figure 2.1 below. As such, the empirically developed ‘health status’ indicators provide a basis for assessing equality in health. While in contrast, equity in health is determined through examining the gaps between observed indicators and normative measures of optimal health, their determinants and the preventability and justifiability of such gaps and inequalities that exist (Chang, 2002: 490).
As denoted in Figure 2.1, there are two broad and contrasting redistributive principles which govern the analysis of the impact of government policies in respect to ‘equity’ in the health care arena: the concepts of ‘horizontal equity’ and ‘vertical equity’. The concept of horizontal equality demands ‘equality for those with equal needs’ (e.g. providing health care to those who are the same in respect to ‘needs’). By comparison, the concept of vertical equality implies the demand of unequal treatment for unequal’s – this is based on a criterion of distribution of health care to those with the most capacity to benefit (e.g. the individual with a greater need for health care will receive more treatment than the individual with a lower need for health care (both concepts shall be discussed in more detail below in terms of the implications for patient needs) (Smith, 2009: 3, Duclos, 2006: 2-3).
2.5 Interpreting Irish health care policy in the context of equality.
The ideal of equality in health care can be defined in a variety of different ways such as in terms of: seeking equal health care for people with equal needs; ensuring equal access to health care and removing inequalities in health outcomes. As Smith (2009: 3) points out, due to the fact that there are various interpretations and definitions of equality, it is useful to link the definitions and alternating conceptualisations of health care provision back to their respective underlying egalitarian philosophical perspectives. In the libertarian perspective, the primary focus is on equality within the rights dimension whereby health care is to be purchased in the market according to the principle of ‘ability to pay’ and a willingness to engage in the market place without government intervention. In such a system, allowing health care to be purchased in accordance with ‘ability to pay’ can risk health care provision being within the purview of those who are wealthy enough to pay for it. As a consequence this would lead to unequal access and would in turn give rise to unequal distributions of health care outcomes (Smith, 2009: 3).

The principle of ‘distribution’ in health care according to the concept of ‘need’ can be attributed to the utilitarian or Rawlsian egalitarian perspective depending on how patient needs are defined. Within the utilitarian construct, emphasis would be placed on the health of everyone and would seek to achieve the maximum level of health in the society. As need is conceptualised in terms of the capacity to benefit, utilitarian theorists may seek distribution of resources for those with the greatest capacity to benefit from such health care. By contrast, a Rawlsian perspective emphasises on the health of the worst-off individual. In this case, if need is defined as being the initial health state, a policy actor adhering to a Rawlsian ethos will apply the ‘difference principle’ and thus direct resources to those with the worst health status. In practice, distributing health care according to need encompasses two generic concepts; horizontal and vertical equity (Smith, 2009: 3). Hence, distributing health care according to a principle of need can have divergent outcomes depending on how need is defined. As Smith (2009: 3) states empirically;
“Two people may have the same initial health status but one has more capacity to benefit from health care than the other. Where need is defined in terms of initial health status (i.e. degree of ill health), distribution according to need between these two individuals employs the horizontal equity principle (equal care for equal need) and the resulting health distribution is equal. However, where need is defined as capacity to benefit from health care, distribution of need in this example will employ the vertical equity principle where unequal care is required to meet unequal capacity to benefit.”

This conceptual ideal of equality of access corresponds with the philosophical perspective of ‘equality of opportunity’. However, ensuring equality of access – through equalising costs of utilisation or maximising attainable consumption of health care – does not necessarily equate with giving rise to equality in other spaces of a patient’s health well-being. From the perspective of linking health care to Sen’s theoretical ideal of equality of capability/outcome, health care would be envisaged as an important ‘functioning’ of a person’s ‘capability set’ and thus the pursuit of equality in the distribution of health care could be categorised as an important attainable goal. Notwithstanding this premise, facilitating everyone with equal utilisation in itself does not guarantee that each person will use the amount of health care required to yield an equal distribution of health care or that health care will be distributed according to need (Smith, 2009: 3). The philosophical egalitarian positions and their applicability to health care provision is summarised in Table 2.1 below.
Table 2.1 - Summary of linkages between philosophical perspectives on equality and equality in health/health care (Sourced from Smith, 2009: 4).

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Libertarianism</td>
<td>Rights</td>
<td>Rights</td>
<td>Health care distributed in the private market (no government intervention).</td>
</tr>
<tr>
<td>Utilitarianism</td>
<td>Utility</td>
<td>Health care need (capacity to benefit)</td>
<td>Health care distributed according to capacity to benefit from health care.</td>
</tr>
<tr>
<td>Rawlsian</td>
<td>Liberties and social primary goods</td>
<td>Health care need (health status)</td>
<td>Health care distributed according to health care needs of the individuals with worst health status.</td>
</tr>
<tr>
<td>Equality of Opportunity</td>
<td>Opportunity</td>
<td>Access to health care</td>
<td>Health care organised to ensure equality of access to health care.</td>
</tr>
<tr>
<td>Sen’s theory of equality</td>
<td>Capabilities to function</td>
<td>Health</td>
<td>Health care organised to achieve equality in health across individuals.</td>
</tr>
</tbody>
</table>

2.5.1 The ideals of ‘Equity’/ ‘Equality’ in the Irish health policy arena

According to Smith (2009), equity has been an important goal in the Irish health care system, which is self-evident in the fact that it was one of four guiding principles in the national health strategy, *Quality and Fairness: A health system for you* (2001). However, there is a sense of ambiguity in respect to identifying what philosophical egalitarian perspective best corresponds with the ethos of equality adopted in the Irish health care system. This is particularly prevalent when assessing the Department of Health’s definition of equality adopted from the World Health Organisation:

“Everyone should have a fair opportunity to attain full health potential and, more pragmatically no-one should be disadvantaged from achieving this potential, if it can be avoided. Inequity refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust” (DOHC, 2001: 17).

Within this definition, a number of conflicting principles can be identified. In the first statement, the concern is placed with equal opportunity – in terms of achieving full

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6 This shall be discussed and expanded in more detail in subsequent chapters, particularly in the interview findings presented in chapter 5.
health potential. While in the second statement, through distinguishing between avoidable and unfair health, depicts an emphasis on the disparities in actual health achievements which in turn denotes a concern with equality in health status (Smith, 2009: 5). Therefore, it is prevalent that in a definitional context, what is meant by equity/equality needs to be revisited and conceptualised in the Irish health policy arena.

2.6 New Public Management – principles of ‘governance’ and ‘efficiency’ in the domain of health policy implementation.

As stated in chapter 1.3.1, the ideal of ‘efficiency’ in the context of this research primarily centres on the principles and practices associated with the model of ‘governance’ utilised in the arena of health care provision/implementation.

In recent decades, the primary theoretical influence in the modelling of public administration practices has been the New Public Management Initiative (NPM). Since the 1980’s the NPM initiative came to fruition in response to countries such as New Zealand, Great Britain and Australia’s engagement in a modernisation process of public sector reform. According to Larbi (1999: 2), the NPM was guided by a multitude of factors in the economic, social, political and technological spheres. Central to this process of change was the desire to achieve improvements in the way government is managed and public services are delivered within the confines of: efficiency; economy; and effectiveness (Larbi, 1999: 2).

A common trend instigating countries to go down the NPM route was the experience of economic and fiscal crises which demanded ‘efficiencies’ and ways to cut costs in the delivery of public services. For instance, the fiscal crisis in the UK in tandem with its unreformed civil service (Whitehall) during the 1970’s led to an International Monetary Fund intervention which demanded financial reform. As such, the fiscal crisis in the UK demonstrated that the active role of the state in managing the economy and in the direct provision of services was being called into question. This transition was symbolised through the paradigmatic shift from Keynesian to monetarist economic policy which elevated the ideal that the market economy was best left to correct itself without active government intervention (Larbi, 1999: 2).
This change in economic thinking and the elevation of the private sector was reflective of the new right/neoliberal criticism of the role, cost and size of government/public bureaucracy. There were also concerns regarding the ability of governments to rectify market/economic problems. More fundamentally however, the Keynesian welfare state model was becoming increasingly seen as inefficient due to its monopolistic role in service provision. Within this neoliberal view, it was perceived that only through market competition could economic efficiency be achieved and that the public can be offered free market choice (Larbi, 1999: 3). As Lindblom posits, the market place: is the most effective allocator of resources; an efficient co-ordination mechanism; facilitates rational decision-making process; and encourages resourcefulness and enterprise (1977 cited in Larbi, 1999: 3).

The ideals of market place as a viable alternative to the public sector came to be represented in the public choice critique which highlighted that the public sector does not promote effective performance due to politicians and bureaucrats having no incentive to control costs. The traditional model of public administration in this sense became outdated and was believed to promote excessive growth and expansion of bureaucratic functions that ultimately become oversupplied and over-extended. Thus, due to its expansionary nature it became impossible to fully control or coordinate organisations which would inevitably lead to bureaucratic failure. This in turn provided the impetus, through the NPM initiative, to instil a framework of privatisation, expenditure controls and the introduction of market based solutions in public service provision. At a political level, the wave of the New Right/NPM was particularly evident in the reforms introduced by the Conservative governments led under Margaret Thatcher in the UK and Ronald Regan in the United States during the 1980’s. Central to the ideological campaign of these two governments during this period was to reverse the growing reliance on the administrative state and to reduce the size of the public bureaucracy (Larbi, 1999: 3-5).

Hence, the public sector reform under NPM sought to provide the means to multiple ends in service delivery. As Pollitt and Bouckaert (2004: 6) state;
“These include making savings (economics) in public expenditure, improving the quality of public services, making the operations of government more efficient, and increasing the chances that the policies which are chosen and implemented will be effective. On the way to achieving these important objective, public management reform may also serve a number of intermediate ends, including those of strengthening the control of politicians over the bureaucracy, freeing public officials from bureaucratic constraints that inhibit their opportunities to manage, and enhancing the government’s accountability to the legislature and the citizenry for its policies and programmes. Last, but not least, one should mention the symbolic and legitimacy benefits of management reform. For politicians these benefits consist partly of being seen to be doing something.”

2.6.1 Characterising the core principles of the New Public Management perspective.

The NPM initiative in many respects can be characterised as being part of a transitioned movement occurring from the traditional forms of ‘government’ to a modernised conception of ‘governance’. According to Rhodes (1996: 652-53), the concept of governance implies ‘a change in the meaning of government, referring to a new process of governing; or a changed condition of ordered rule; or the new method by which society is governed’. In addition, Rhodes (1996: 653) specifies that there are six dimensions to analysing the concept of governance; as the minimal state; as corporate governance; as the New Public Management; as ‘good governance”; as a ‘socio-cybernetic system”; and as a ‘self-organising of networks’. All of which imply a reduced role for the State and a consideration of other sources such as the private sector/community and voluntary sector in the active provision of social services (Rhodes, 1996: 653). Therefore, in this context, the NPM initiative formed part of a transition occurring in respect to evaluating the administrative/governing structures in society. At a foundational level, the term NPM can be characterised as having two meanings; ‘managerialism’ and the ‘new institutional economics’. In the context of managerialism, this involves the application of private sector management techniques into the public sector. According to Hood (1991: 4-5), the concept of managerialism
comprises of seven doctrinal components which are restated in Table 2.2 below\(^7\). As such, the NPM initiative through its principled stance is designed to ‘slow down or reverse government growth’ in terms of excessive public spending and staffing. It also symbolises the increased use of the ‘private sector techniques’ in the institutional environment of public services provision – through the introduction of practices such as privatisation and quasi-privatisation – rather than solely focusing on government institutions (Hood, 1991: 3). The characterisation of NPM, as the new institutional economics, depicts the introduction of incentive structures – e.g. market competition – into public service provision. In this sense, it stresses the disaggregating of the bureaucracy; greater competition through the practice of contracting-out and quasi-markets; and consumer choice (Rhodes, 1996: 655).

Table 2.2 ‘Doctrinal components of new public management.’ (Sourced from Hood, 1991: 4-5).

<table>
<thead>
<tr>
<th>Doctrine</th>
<th>Meaning</th>
<th>Typical Justification</th>
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<tbody>
<tr>
<td>1. Hands-on professional Management in the public sector</td>
<td>Active, visible, discretionary control of organizations from named persons at the top, ‘free to manage’</td>
<td>Accountability requires clear assignment of responsibility for action, not diffusion of power</td>
</tr>
<tr>
<td>2. Explicit standards and measures of performance</td>
<td>Definition of goals, targets, indicators of success, preferably expressed in quantitative terms, especially for professional services (cf. Day and Klein, 1987; Carter, 1989)</td>
<td>Accountability requires clear statement of goals; efficiency requires ‘hard look’ at objectives</td>
</tr>
<tr>
<td>3. Greater emphasis on output controls</td>
<td>Resource allocation and rewards linked to measured performance; breakup of centralized bureaucracy-wide personnel management</td>
<td>Need to stress results rather than procedures</td>
</tr>
<tr>
<td>4. Shift to disaggregation of units in the public sector</td>
<td>Break up of formerly ‘monolithic’ units, unbundling of U-form management systems into corporatized units around products, operating on decentralized ‘one-line budgets and dealing with one another on an ‘arms-length’ basis</td>
<td>Need to create ‘manageable’ units, separate provision and production interests, gain efficiency advantages of use of contract or franchise arrangements inside as well as outside the public sector</td>
</tr>
</tbody>
</table>

\(^7\) It is important to note in this context, as Hood and Peters have pointed out, there is no set definitive postulates outlining the principles of NPM (2004: 268). Rather the perspective has grown through examining the experiences of practitioners, such as in the case of the New Zealand Treasury where the ideas of NPM began to be debated and attracted attention. This in turn led various authors to characterise and list divergent features of the NPM doctrine (Hughes, 2012: 88).
Another significant feature of the NPM perspective as a driving force in respect to delivering efficient ‘governance’ is its renewed conception of the role of government in the policy ‘making’ and ‘implementation’ arena. This is depicted in its derivation of the ‘steering’ and ‘rowing’ analogy, whereby steering infers the process of making policy decisions while the process of rowing is concerned with service delivery. According to advocates of the NPM perspective, the traditional operation of the public bureaucracy and government is conceived to be a redundant tool in practices associated with rowing – the implementation of policy. In its place, Osborne and Gaebler (1992: 20 cited in Rhodes, 1996: 655) propose an ‘entrepreneurial’ form of government which is based on ten core principles:

“Most entrepreneurial governments promote competition between service providers. They empower citizens by pushing control out of the bureaucracy, into the community. They measure performance of their agencies, focusing not on inputs but on outcomes. They are driven by their goals – their missions – not by their rules and regulations. They redefine their clients as customers and offer the choices … They prevent problems before they emerge, rather than simply offering services afterwards. They put their energies into earning money, not simply spending it. They decentralize authority, embracing participatory management. They prefer market mechanisms to bureaucratic mechanisms, and they focus not simply on providing public services, but on catalysing all sectors – public private and voluntary – into action to solve their community’s problems.”

As such, a primary concern of NPM is with having an inclusive attitude towards; competition, markets, customers and outcomes in public service deliver. In many
respects, this transformation of the public sector ethos in this regard has the effect of facilitating an advanced role for government/public bureaucracy-civil service in the practice of steering (policy decision making) and a lesser role in the process of rowing (policy implementation)\(^8\) (Rhodes, 1996: 655).

In characterising the NPM perspective in a modern context, Pollitt (2001: 474) has attempted to harmonise and summate the various defining features of this approach made by commentators into seven main components. These are as follows;

- “A shift in the focus of management systems and management effort from inputs and processes to outputs and outcomes.
- A shift towards more measurement, manifesting itself in the appearance of batteries of performance indicators and standards.
- A preference for more specialized, ‘lean’, ‘flat’ and autonomous organizational forms rather than large, multi-purpose, hierarchical bureaucracies.
- A widespread substitution of contract or contract–like relationships for hierarchal relationships.
- A much wider than hitherto us of market or market-like mechanisms for the delivery of public services (including privatization, contracting out, the development of internal markets etc.).
- A broadening and blurring of the ‘frontier’ between the public and private sectors (characterized by the growth of public/private partnerships of various kinds and the apparent proliferation of ‘hybrid’ organizations).
- A shift in value priorities away from universalism, equity, security and resilience towards efficiency and individualism.”

The cumulative effect of these core components is that it enables the development of a ‘smaller’ public sector which is more intensively focused on the practice of efficiency and continuous improvement. In this process, it comprises of small, core ministries (responsible for strategy) and a range of specialised, semi-autonomous agencies (responsible for the implementation of policy). This interpretation of NPM principles also enshrines within the public sector the operation of clear performance frameworks that specify budgets and expected results. Further to this, it also advocates public sector

\(^8\) The establishment of autonomous agencies at ‘arms-length’ from the traditional civil service department is an example of a lesser role for government in the practice of rowing.
involvement in the extensive utilisation of market and market-based mechanisms which additionally involves working in partnership with for-profit and voluntary sector organisations (Pollitt, 2001: 474).

2.6.3 Principles of ‘governance’ and ‘efficiency’ in the Irish context: Assessing the Strategic Management Initiative.

In a similar vein to what was occurring in other countries, Ireland also engaged in its own niche of public sector reform which was to a large extent reflective of the trends surmounting from the NPM ideology of delivering efficiencies in public administration (Collins, 2007: 30). The Strategic Management Initiative (SMI) and the Delivering Better Government (DBG) report formed the backdrop to this process and for the past three decades oversaw the instituting of a design for change in Irish public sector reforms (Byers, 2014: 4; Collins, 2007: 30-39).

2.6.4 The Strategic Management Initiative: the transition from public administration to public management.

Attempts at public service reform have a long history in the Irish case. The most notable reform attempts being the Devlin Report, 1969 and Serving the Country Better, 1985. Both reports contained objectives that sought to modernise and improve the efficiency and effectiveness of the Irish public service. However, due to Ireland’s accession into the European Union in 1973 and the economic crisis of the 1980’s, public sector reform was not seen as a pressing concern for the political sphere (OECD, 2008: 76-77; MacCartaigh, 2008: 73-74). It was not until the introduction of the Strategic

9 The Devlin Report, 1969 recommended a wide-array of reforms aimed at improving the structures within the civil service as a means of meeting the needs of a changing population. The reform proposed was based on two underlying principles; (a) a greater emphasis on policy-making and (b) a need for greater integration and coordination in the public service. However, the most radical reform proposed was that each government department be divided along ‘policy development’ and ‘policy execution’ lines (OECD, 2008: 76).

10 Serving the Country Better, 1985 was aimed at improving the efficiency and effectiveness of the civil service. In this regard, it was envisaged to introduce a management system based on corporate planning and personal responsibility for results, costs and service. This attempt at public service reform was to a significant extent driven by an impetus to develop a more customer-responsive public service that met the changing needs of the public (MacCartaigh, 2008: 74).
Management Initiative in the 1990’s that a serious reform agenda was contemplated for the Irish public service.

As a concept, strategic management has been defined by Elcock (1993: 55 cited in Collins, 2007: 35) as being a process concerned with two activities;

“… [first, the] making of strategic choices – setting the directions in which the organisation is to move in the future. The second is strategic implementation – ensuring that the organisation has the right structures, processes and culture to carry out the policies determined by the strategic choices its governors have made”

In the Irish context, the Strategic Management Initiative (SMI) formed part of a modernisation ethos which was generated from the rapid development of the Irish economy and the gaining popularity of international ideas concerning public service performance. Additionally, the European Union also formed a significant part in encouraging the modernisation process. In response to these factors, this culminated in the launch by the then Taoiseach Albert Reynolds of the SMI in 1994 (OECD, 2008: 77; MacCartaigh, 2008: 74)

One of the most significant developments which facilitated this modernisation process was the government’s creation in early 1994 of the co-ordinating Group of Secretary Generals drawn from nine departments, with the authorisation to oversee and direct the initiative and report to the government on the progress of the programme. Within the Co-ordination’s remit it had to (cited in OECD, 2008: 77-78):

- consider the development of a strategic management process on the Irish Public Service;
- facilitate the preparation of Strategy Statements at the individual department level; and
- oversee the allocation of a fund to assist departments to acquire expertise in strategic planning and organisation development (cited in OECD, 2008: 77-78).

At its formal launch in May 1994, the then Taoiseach Albert Reynolds outlined that the primary objectives of the SMI were to:

- enhance contribution of the public service to national development;
- provision of top-quality services in a timely and efficient manner;
- effective use of available resources. (cited in MacCartaigh, 2008: 75).
As a programme of modernisation, the SMI aimed to benefit from retaining the Co-ordination group of secretaries to oversee the implementation process. As within a few months of its launch, all government departments and public service offices under the aegis of departments had to prepare strategy statements that set out their overall divisional goals and objectives which then had to be submitted Co-ordinating group of secretaries. The preparation and procedures associated with the development of ‘strategy statements’ came to be formalised further through the enactment of the Public Service Management Act, 1997, which will be discussed below.

2.6.5 Delivering Better Government: A blueprint for public service reform.

In March 1995, the government mandated Co-ordinating Group of Secretaries once again to:

- review existing systems of making decisions, allocating responsibility and ensuring accountability in the Irish state; and
- bring forward for government consideration, proposals for an integrated programme to modernise the systems and practice in question, and for the consequent modernisation of existing personnel and financial management in the Civil Service. (cited in OECD, 2008: 78)

Responding to this mandate, the Co-ordinating Group of Secretaries General submitted a report to the government in May 1996, which was entitled ‘Delivering Better Government’. The document proved to be significant as it outlined the vision for reform in the Irish Civil Service, and later was broadened to include the wider Public Service. The focal point of DBG was to build on the overarching aims established by the SMI which was to ensure that the public service was sufficiently responsive, flexible and innovative to meet the needs of a modern, highly diversified and increasingly complex society within increasingly changing economy (OECD, 2008: 79).

2.6.6 Implementing the ‘Delivering Better Government’ programme; Public Service Management Act, 1997.

The SMI reforms instigated within the civil service and indeed across the public service have been significant in transforming the internal structures rather than the range of functions conducted by officials. From this standpoint, the civil service has been modernised in light of the ideals of strategic management and its analytical model of
structural decision making and accountability. In terms of providing further insight into the operative practice of the SMI, PA Consulting has illustrated in diagrammatic form the management process in Figure 2.2 below;

Figure 2.2 Interrelationship between core components of SMI (Sourced from PA Consulting 2002: 12).

In terms of putting the modernisation programme on a statutory basis, the Public Service Management Act was enacted in 1997 which gave effect to the management structure. Further to this, the Act also enhanced management, effectiveness and transparency of departments and offices. This in effect, facilitated the instituting of mechanisms for increased accountability for public servants. Additionally and perhaps most significantly, the Act also put on a statutory basis the service-wide-vision instigated by the DBG programme which was the requirement that each department or office would produce a Statement of Strategy. In essence, this legislative basis not only had the effect of requiring government Departments to produce a Strategy Statement, but to also report annually on the achievement of the objectives set in the strategy outlined. In turn, this assured consistency in approaches utilised across the civil service (OECD, 2008: 79-80).

Despite the evolutionary changes which came under the guise of the SMI, the OECD (2008: 24) has reported that:

“Further implementing the reform programme will require more firmly embedding reforms in the civil service and implementing the provisions for managerial devolution as originally foreseen
under the SMI. As part of a move towards a more integrated Public Service, the next set of reforms should also renew focus on updating the capacity, performance, citizen-focus and governance of the broader public service.”

Hence, it is suggested that the structure of public service reforms moving forward need to be more responsive and efficient rather than being simply subject to a new set of controls. Furthermore, it is also highlighted that there is a need to make reforms more mutually supportive and consistent both within the internal environment and across different sectors and agencies.

As such, the OECD suggests that the instilment of coherence in the reform process proves difficult due to the incremental approach of successive governments to public service reform. While the SMI/DBG was significant in providing the initial vision and remains to be valid, the Irish public service now needs to consider how reforms fit together and support each other. Despite the incremental approach to reform providing stability and consensus, it has also led to the development of isolated reforms overtime rather than a coherent reform agenda. The subsequent challenge then is to renew the vision originally envisaged by the SMI and in the process take into account the coherence of the reforms and how they interact with one another\textsuperscript{11}. Furthermore, another significant challenge highlighted regarding the modernisation agenda is the need to expand reform beyond the civil service to the wider public service. Originally, the SMI/DBG was a framework designed for the civil service with the expectation that it would eventually ‘spill over’ to the wider public service. However, this has only occurred to a limited extent. In practice, the reform process has taken longer than expected for the wider public service as a whole. As such, the reform agenda has only been adapted to varying degrees by public sector bodies. Thus, while significant reforms have emerged within the public service, there has been limited ability to capture and replicate innovation (OECD, 2008: 24-25).

\textsuperscript{11} One such example of a lack of coherence is in respect to the emergence of ‘agencification’ in recent decades. Due to the absence of proper governance structures and performance incentives this has led to further fragmentation and reduced transparency in the public service (see chapter 5, section 5.7.3).
2.6.7 Strategic Management Initiative: impact of governance on the Irish health system.

The SMI had a significant influence on the governance structures of the Irish health care system. The earliest strategy statement to emerge from the Department of Health was the *Shaping a healthier future: A strategy for effective healthcare in the 1990’s* introduced in 1994. This report proved to be significant as it brought to the fore the importance of developing on a national basis a strategy to guide the health care system in the determination of its priorities and to underpin all planning in the health care arena for the following four years (Byers, 2009: 16). The underlying principles in which the strategy was founded were: equity; quality of service; and accountability in health care delivery (DOH, 1994: 10-12). Further to this, the strategy also reviewed the organisational structures of the health care system and proposed legislation to remedy discrepancies in the health boards governance structures. In tandem with this, the strategy also reviewed the eligibility structure of public health care provision under the General Medical Service (medical card system) and also the contributions which can be derived from the private sector in meeting the objectives of the strategy. (DOH, 1994: 30, 35-36).

The strategy proved to be significant in providing the impetus for the service planning legislation introduced in the Health (Amendment) Act, 1996 which had the effect of establishing a service planning process on an annual basis (DOH, 1996). Therefore, with the introduction of service planning in tandem with the *Strategy Statement: Working for Health and Well-being 1998-2001* in 1998, the SMI management tools were evident in the Irish health care system. The legislation and the strategy report signalled the instilment into the governance structures of the Irish health care system, the practices of service planning and giving strategic direction into the Irish health services. This is particularly prevalent when taking into account the ‘high-level objectives’ of the strategy statement which were;

- to support the Minister in the formulation, development and evaluation of health policy and the discharge of all ministerial functions;
- to plan strategic development of services, through partnership and consultation with health boards, the voluntary sector, other relevant government departments and other interests;
- to encourage the attainment of the highest standards of effectiveness, efficiency, equity, quality and value for money in the health delivery system;
- to strengthen accountability at all levels of the health service;
- to encourage the continuing development of a customer service ethos in the delivery of health services;
- to optimise staff performance, training and development;
- to represent the Irish interest in EU, WHO and international fora relating to health matters.

(DOH, 1998: 8)

In analysing the developments in health care during this period, Byers highlights that while the crucial link between ‘resources’ and ‘clear objectives’ were emphasised, the legislation did not address the complexity which is associated with health care planning. Additionally, it was highlighted that the ethos of ‘service user participation’ in the decision making process was not promised to be legislated for in the strategy (2009: 17). Nonetheless, the legislation proved to be widely welcomed in the political sphere due to it altering the framework of accountability for health service management. The reason for this rests on the premise that its primary focus was on how to improve financial accountability and it obliged the existing health boards to produce an annual service plan (Byers, 2009: 17). This formed part of a vision to secure the ‘most beneficial, effective and efficient use of resources’ (DOH, 1996 cited in Byers, 2009: 17).

However, it was not clear in legislative terms how this strategic vision was to be implemented by the health boards. Despite this, it was assumed that the strategic idealisms envisaged in the strategy statement such as the provision of health services that would be equitable, accountable and quality focused, planned with the participation of users and all those charged with the delivering of services would in effect be achieved through the service planning legislative Act, 1996. Therefore, it was envisaged that the process of implementation was to be deliberated at the health board or Department of Health (DOH) level (Byers, 2009: 17). As such, there was a formal separation of policy decision making and policy implementation, as previously envisaged in the Devlin report, 1969 discussed above.
In recent years, the second health strategy to be introduced *Quality and Fairness: A health care system for you*, (2001) proved to be significant in advancing the governance structures of efficiency outlined in the SMI through providing strategic direction to the Irish health care system in the subsequent decade following its publication. The document proved to be cohesive in that it outlined concisely the Department of Health and Children’s (DOHC) aim to develop a sophisticated planning process which was founded on strategic managerial tools such as having common strategic objectives and clear performance measurement indicators. In this context, the health strategy, through its strategic planning of services, has been depicted as a significant operative tool in guiding policy makers and service providers in tandem towards the delivery of an articulated vision (Byers, 2009: 17). The vision outlined by the health strategy was to provide;

“A health care system that supports and empowers you, your family and community to achieve your full health potential; A health system that is there when you need it; that is fair, and that you can trust; A health care system that encourages you to have your say, listens to you, and ensures that your views are taken into account” (DOHC, 2001: 11).

In terms of implementing this vision, the strategy articulated four principles which would support this vision which were; ‘equity and fairness’, ‘a people-centred service’, ‘quality of care’ and ‘clear accountability’ (DOHC, 2001: 12).

In this regard, the *Quality and Fairness* strategy proved to be significant in the reform of the Irish health services not only because it invoked the efficient governance methods of the NPM/SMI but because it formed the stimulus for subsequent reforms following its publication. The most notable reform to arise in this context was the enactment of the Health Act, 2004 which led to the creation of the Health Service Executive (HSE) Agency. The HSE in many respects encompasses much of the principles incorporated within the NPM/SMI orthodoxy in terms of for instance; disaggregating of the public sector through the establishment of executive agencies to implement policy and also instilling an essence of ‘hands on professional management’ in that process. This is particularly reflected in the description provided by the OECD
(2008: 257) in respect to the function of the HSE within the governance structure of the Irish health care system;

“...the HSE is responsible for the management and delivery of health and personal social services within the policy, legislative and resource allocation framework determined by the Minister for Health and the government. ...the CEO of the HSE is accountable as the Accounting Officer for the expenditure by the HSE, the Minister for Health and Children is politically accountable for the implementation of policy by the HSE and the overall performance of the health service.”

Therefore, the core responsibility of the HSE is with the strategic planning of the Irish health services at a national level. The scope of its roles and functions in health service delivery, of which it is held accountable, are realised through the organisation’s adherence to its National Service Plan (NSP) and three year corporate plans. These plans reflect the overall strategic policy held by the DOH regarding the development of the Irish health services (Byers, 2014: 4). The governance structure which encompassed at its core the concept of efficiency through the implementation of the SMI has continued to evolve which is prevalent in the publication of the recent health strategy publication, *Future Health: A Strategic Framework for Reform of the Health Service, 2012-2015*. This latest strategy statement has continued to reinforce the significance of infusing an ethos of strategic planning in health service delivery.

In the context of the theory of NPM and the SMI orthodoxies, it is apparent that the concept of efficiency is encapsulated in the process of: strategic planning; the reorienting of administrative focus from ‘inputs’ to ‘outputs’ in the delivery of public services; the instilment of accountability in the public service; and the delivery of quality customer service. This is particularly prevalent in the context of the Irish health care system where the core principles of the NPM and SMI are reflected in the rhetoric of health strategies published in the aftermath of the SMI and also in the establishment of the HSE statutory agency to execute efficiently policy at arms-length from the DOH.
2.7 Conclusion

The principles of ‘equality’ and ‘efficiency’ form a central theoretical cornerstone in this research. This rests on the premise that when analysing successive reforms, both principles to varying degrees are reflected as central tenets in the process of shaping health care provision.

In this chapter, a review of the literature related to central philosophical perspectives on equality was presented. There was, in the social policy arena, a particular focus on the influence of the perspectives: social citizenship rights; utilitarianism; libertarianism; Rawls theory of social justice and ‘fair’ equality of opportunity; Sens egalitarian theory of equality of outcome/capability; Baker et al. theory of equality of condition and finally the principled ideal of equity. Each egalitarian perspective offers a distinctive prescription for the organisation of social policy and health care provision in egalitarian terms. From this theoretical examination, it is evident that the structures of Irish health care system do not lend itself towards an ‘outright’ egalitarian premise through for instance universal access or equality of outcome in health status. On the contrary, as the interview findings posit in chapter five, the focal point of public policy has been on instilling a ‘spirit of fairness’ in the delivery of health care provision. This is particularly manifested through the existence of the ‘mixed motives’ of libertarian and egalitarian precepts which currently governs the framework of health service delivery (see chapter 1, section 1.1).

This chapter also reviewed the literature surrounding the New Public Management Initiative and its origins from the ideals of neoliberalism and New Right political orthodoxies. It is evident in the Irish case, that the principles of governance espoused under the New Public Management came to be reflected in the Strategic Management Initiative. The principles of ‘efficiency’ and ‘governance’ contained in the NPM/SMI proved to have an indelible impact in shaping the mode of health service delivery in recent decades. In this context, the precept of efficiency is particularly manifested in the Irish health care system through infusing in the policy process an emphasis on: ‘strategic
planning’; ‘outputs’; ‘accountability’ in service provision, and the delivery of a ‘quality’
customer service.

The principles of ‘equality’ and ‘efficiency’ derived here will be discussed further in
Chapter Six in relation to the interview findings and the research questions of this study.

In the next chapter, the literature surrounding the theory of institutionalism will be
discussed.
Chapter Three

Theorising the ‘policymaking environment’ of the Irish health care system through the conceptual prism of institutionalist analysis.

3.1 Introduction

This research seeks to examine how the policymaking environment addresses issues of ‘equality’ and ‘efficiency’ in the arena of Irish health care provision. In this chapter, a review of the relevant literature on the theoretical variants of the ‘new’ institutionalist perspective shall be undertaken in an attempt to address the overarching aims and objectives of this study. Furthermore, this chapter shall focus on three central explanatory themes to emerge from institutionalist interpretations of the policymaking sphere namely: ‘continuity’ ‘institutional stability’ and ‘change’.

Section 3.2 provides a conceptual discussion on institutionalism. It begins with chronicling the theoretical evolution of the ‘new’ institutionalist approach. This section also provides a conceptual definition of institutionalism as an operative theory to understanding the intricacies associated with the policymaking process.

Section 3.3 describes the historical institutionalist perspective. In this part, it is explored how the ‘formal’ and ‘informal’ structures of institutions shape and constrain the goals, opportunities and actions of individuals and groups that operate within an institutional setting. Further to this, this part shall discuss the ‘persistence’ of policy patterns through analysing two central theoretical tools associated with the historical institutionalist perspective namely; path-dependent analysis and critical junctures.

Section 3.4 delves into the theoretical core of the sociological institutionalist perspective. In this part, the internal workings of an institutional policymaking environment are explored. This is primarily analysed in terms of how behaviour comes to be constrained by prevailing cultural frames; both cognitive and normative, in
conjunction with regulative structures and activities as a means of ensuring stability in the institutional environment.

Section 3.5 describes the ‘fourth’ new institutionalism to emerge in recent times, discursive institutionalism. As the previous two parts above will exhibit, ‘continuity’ rather than ‘change’ proves to be a central facet emerging from the historical and sociological institutionalists’ schools of thought. By contrast, this section shall describe how the study of discursive institutionalism enlightens our understanding of institutional change through observing the interactive processes which takes place between participants within the institutional environment. In this context, it is explained how the dynamisms derived from ideas and discourse in the policymaking field facilitate institutional change through a communicative and coordinative discourse. Furthermore, this section also interprets the concept of change through the process of social learning and paradigm shifts, which occurs within prevailing policy cycles.

3.2 The emergence of ‘New’ Institutionalism as a theoretical core in political science.

To contemplate fully the contributions of ‘new’ institutionalism as theoretical school of thought in political science, Immergut argues one must evaluate its distinction to the behavioural movement which emerged in the 1950’s and 1960’s (1998: 6). From the outset, the behavioural revolution sought to justify, as Truman points out “an orientation or point of view which aims at stating all of the phenomena of government in terms of observed and observable behaviour of man” (Truman, 1951 cited in Immergut, 1998: 6). While the central premise of the behavioural approach was on developing a scientific method of rigorous hypothesis testing based on empirical observation; science in itself was not perceived to be a constitutive factor in this process. On the contrary, this school of thought focused on aspects such as: how people vote; and what a political actor grants his/her constituents as being a central element of its analysis (Immergut, 1998: 6).

As such, the behavioural approach held the assumption that ‘human and social behaviour can be explained in terms of general laws established by observation’ (Przeworski and Teune, 1970: 4 cited in Schmidt, 2006: 101). In addition, most
behaviouralism scholars sought to develop precise techniques by which to measure data and to demonstrate the validity of law-like theories (Kirkpatrick, 1971: 71-73 cited in Schmidt, 2006: 101). However, as Immergut points out, this method of analysis was perceived to have contained ‘flaws’ which undermined its theoretical approach and consequentially marked a point of departure for the development of the ‘new’ institutionalist perspective, containing the variants of historical, sociological and rational-choice institutionalisms.

As a theoretical approach, ‘new’ institutionalism proved to be less concerned with rejecting the premises of ‘old’ institutionalism, as its descriptive nature of the ‘formal’ structures of governance are treated as background knowledge (Bell, 2002: 4; Schmidt, 2006: 101). On the contrary, the primary focus of this theoretical approach was to provide a ‘counter assessment’ to that posited by the behaviouralist perspective. One of the central reasons for this rests with the perception of the behaviouralist approach being ‘plagued’ by excessive quantification and under-theorizing (Schmidt, 2006: 101). More fundamentally, the ‘new’ institutionalist approach rejected the proposition that ‘observable behaviour’ was a central element in the political analysis of policy outcomes. Instead, it is argued that behaviour ‘cannot’ be understood without reference to the institutional setting within which such behaviour occurs. Hence, the ‘behaviour’ of policy actors occurs and corresponds with the ‘rules’ and ‘norms’ dictated within the institutional setting (Immergut, 1998: 6).

This point is echoed further by Thelen and Steinmo who state that due to mainstream behaviouralist theories being primarily concerned with the characteristics, attitudes, and behaviours of the individuals and groups in attempting to evaluate

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12 This would be conducted through analysing readily quantified data, such as voting and public opinion via electoral studies, survey research, and opinion polling, became the primary focus (Schmidt, 2006: 101).

13 The concern of political science in ‘old’ institutionalism centred on the formal aspects of government, which included law and public administration (Peters, 2012: 4; Bell, 2002: 3). As Rhodes states, ‘old’ institutionalism synthesised an approach which consisted of a detailed analysis of the political, legal and administrative structures within a country (1995: 42-43). Thus, these early institutionalists’ focused on evaluating how well specific institutions (such as the constitution of a country) correlated with democratic norms and the principles of responsible governance (Bell, 2002: 4). As a theoretical approach then, ‘old’ institutionalism proved to be ‘descriptive’ and ‘analytical’ in focus (Kavanagh, 1991: 482).
political outcomes, they frequently missed crucial elements of the playing field (1992: 5). This resulted in a lack of adequate answers to questions such as why these political behaviours, attitudes, and the distribution of resources among contending groups contrasted from one country to another. In demonstrating this empirically, Thelen and Steinmo, suggest that the interest group theories which focused on the central ‘characteristics’ and ‘preferences’ of pressure groups themselves are not capable of taking into account why other interest groups with equal organisational structures could not influence policy in the same way or to a similar extent in different national contexts (1992: 5). Therefore, this asserts that the behaviourism approach failed to provide a succinct account of the institutional context through which interest groups sought to influence.

In terms of contextualising the distinctions between these two theoretical perspectives, Immergut argues that there are three aspects to the institutionalist critique of the behavioural approach. The first critique centres on the behavioural assumption that political behaviour reveals ‘preferences’. This entails that one must rely on observing the behaviour of an actor as a means of identifying preferences. In turn, this assumes that the ‘expressed’ preferences are considered to be the ‘real’ preferences of individuals. However, for ‘new’ institutionalism, there is a distinctive difference between preferences that are ‘expressed’ and those which are ‘real’. This relates to the institutionalist assumption that there may be a number of different reasons why under a particular set of circumstances, that an individual may make a political choice that deviates from the choice that same individual would make under other circumstances. For instance, in the policy making remit, individuals in deciding their preferences on the future direction of policy may believe that the outcome they hope for is not feasible which in turn leads them to vote for an alternative that is not their first choice but one that has the advantage of being realisable. In this sense, institutionalists are primarily interested in analysing why policy actors choose one particular definition of interests and not some equally plausible alternative. The focus on defining interests reflects how institutionalists place significant emphasis on analysing the results of the political process. Therefore, the institutionalist theory aims to expose and analyse the
discrepancy between potential interests and those that come to be expressed in political behaviour (Immergut, 1998: 7).

The second institutionalist critique relates to the behaviouralism assumptions on the summation of preferences or the aggregation of individual behaviours into collective phenomena, which is perceived as exceedingly problematic (Immergut, 1998: 7). As Dahl argues,

“analysis of individual preferences cannot fully explain collective decisions, for in addition we need to understand the mechanisms by which individual decisions are aggregated and combined into collective decisions” (1961:770 cited in Immergut, 1998:7).

However, the behavioural approach assumes that preferences can be aggregated and in general view mechanisms for the aggregation of interests is perfectly efficient. The core branches of the institutionalist approach reject the possibility of interest aggregation due to their belief that decisions cannot be based on the premise of aggregating individual preferences. The central rationale for this is based on an institutionalist assumption that it is not possible to add interests together due to the complexity of human nature (Immergut, 1998: 7).

From this standpoint, the ‘new’ institutionalists school of thought are primarily interested in analysing why policy actors choose one particular definition of interests and not some equally plausible alternative. The focus on defining interests reflects the ‘new’ institutionalists placing significant emphasis on analysing the policy outcomes of the political process. Therefore, the institutionalism theory aims to expose and analyse the discrepancy between potential interests and those that come to be expressed in political behaviour (Immergut, 1998: 7).

The final critique of the behaviouralism approach is normative in nature. In this regard, institutionalists argue that political behaviour and collective decision making is an artefact of the procedures used to make decisions (Immergut, 1998: 8). Therefore, within this critique institutionalists argue that preferences and decisions are artefacts of the institutions through which ‘rules’ and ‘procedures’ distort the preferences of individuals considerably.
Hence, the emergence of the ‘new’ institutionalist reflects a process of ‘bringing institutions back in’ in the analysis of political system. As an operative theory then, institutions can be derived from formal organisational arrangements to elements of patterned behaviour existent through roles, rules, and in some instances scripted behaviour (Bell, 2002: 2). According to North, an institution represents ‘any form of constraint that human beings devise to shape human action’ (1990: 4). For Hall institutionalism is prevalent in ‘the formal rules, compliance procedures, and standard operation practices that structure the relationship between individuals in various units in polity and economy’ (1986: 19). Therefore, a central theme within this theoretical approach of understanding policy outcomes; is the role in which compliance to institutional rules, norms or operating procedures shapes that process toward a particular direction. In subsequent sections, the ‘new’ institutionalists’ perspectives of historical, sociological and discursive institutionalisms shall be presented in the context of their impact in shaping policy outcomes in terms of ‘continuity’, ‘institutional stability’ and ‘change’.

3.3 Historical Institutionalism.
At a foundational level, the historical institutionalist perspective is founded on the assumption that political institutions and public policies enacted previously structure the behaviour of policy actors, elected officials and vested interest groups during the policymaking process in the present (Béland, 2005: 3). As a theoretical approach, historical institutionalism encompasses various argumentations and hypothesis; however it is nonetheless united by three basic claims. As Ikenberry (1994: 2) points out;

“[f]irst, policy outcomes and orientations of a polity are mediated in decisive ways by its core political structures – such as the institutional configurations of government and party. The structures of a polity shape and constrain the goals, opportunities, and actions of the groups and individuals that operate within it. Second, to understand the how these institutional constraints and opportunities are manifest, they must be placed within an historical process – timing, sequencing, unintended consequences, and policy feedback matter. Third, institutional structures have an impacts they facilitate or limit the actions of groups and individuals – which means that institutions are never offered as a complete explanation of policy outcomes”.
In this sense, the impact of institutions tends to be analysed through an assessment of how they interact with other aspects such as: societal interests; culture and ideology; and new policy ideals. Furthermore, the theoretical underpinnings of historical institutionalism stresses that the goals and actions of individuals, groups and classes are problematic, due to these factors being shaped by the institutional environment in which they operate. Therefore, one of the central theoretical interests of this school of thought is to demonstrate how a policy actor’s interest gets defined and pursued within the institutional organisation. Analysts within the school of historical institutionalism have no choice but to pay close attention to the specific historical and political environments in which policy actors operate (Ikenberry, 1994: 2-3).

As such, political institutions are depicted in terms of the ‘constraints’ and ‘opportunities’ which they pose for actors operating in the policymaking arena (Steinmo et al., 1992; Immergut, 1998; Skocpol, 1992). The primary focus for institutionalist scholars is to analyse how institutions impact on a political/policy actor’s behaviour and strategies. In an empirical sense, Immergut’s (1992) study of health care reform in Sweden, Switzerland and France demonstrates; due to the institutional configuration of the Swiss federal system, the medical profession in that country encompassed significant political influence and can oppose legislation more easily than their counterparts in France and Sweden. Within this context, the historical institutionalist perspective is representative of an attempt to clarify how political struggles “are mediated by the institutional setting in which [they] take place” (Ikenberry, 1988: 222-23 cited in Thelen and Steinmo, 1992: 2).

### 3.3.1 Historical Institutionalism: conceptual definition of institutions.

In terms of depicting how historical institutionalists’ define ‘institutions’, scholars of this perspective derive a definition which encapsulates both formal organisations and the informal rules and procedures that structures the conduct of participants. This is reflected in Hall and Taylor’s definition where they state that institutions are reflective of the;
“...formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or political economy. They can range from the rules of a constitutional order or the standard operating procedures of a bureaucracy to the conventions governing trade union behaviour or bank–firm behaviours” (1996: 938).

In putting this into context, Ikenberry argues that a definition of historical institutionalism can be empirically broken down into three levels that “range from specific characteristics of government institutions, to the more overarching structures of the state, to the nation’s normative order” (1988: 226 cited in Thelen and Steinmo, 1992: 2). Therefore, scholars of this perspective generally tend to be primarily interested in how a whole range of state and social institutions indelibly shape the preferences of political actors, and in turn both define their interests and structure their relations of power to other groups (Thelen and Steinmo, 1992: 2).

With regards to how ‘institutions’ can be attributed to an analysis of the process of policymaking and politics generally within the confines of historical institutionalism; Hall (1986) stresses that institutions play a central role in shaping the goals of political actors. Furthermore, he also posits that institutions have the effect of structuring power relations amongst political actors, through privileging some interests and disadvantaging others. As Hall states;

“Institutional factors play two fundamental roles in this model. On the one hand, the organization of policy-making affects the degree of power that any one set of actors has over the policy outcomes...On the other hand, organizational position also influences an actor’s definition of his own interests, by establishing his institutional responsibilities and relationship to other actors. In this way, organizational factors affect both the degree of pressure an actor can bring to bear on policy and the likely direction of that pressure.” (1986: 19).

From this standpoint, Thelen and Steinmo state it is important to note that while institutions are projected as an aspect which constrains and refracts politics, they are never the sole cause of the outcomes produced (1992: 3).
3.3.2 Conceptualising ‘continuity’ in public policy: *the theoretical process of path-dependency within historical institutionalism.*

At a practical level, one of the basic fundamentals of the historical institutionalist approach is that the policy choices made when an institution is being formed ‘will have a continuing and largely determinate influence over the policy far into the future’ (Peters, 2012: 70). The theoretical term which depicts this process is ‘path-dependency’. A conceptual idealism within historical institutionalism that denotes the practice of when a government policy or organisation traverses down a path-dependent trajectory in which there is an ‘inertial tendency’ to sustain the initial policy choices (Peters, 2012: 70). Hence, the theme of ‘continuity’ in the policymaking process forms a central cornerstone to this theoretical variant within the ‘new’ institutionalisms.

From this contextual standpoint, it is prevalent that historical institutionalism is a construct that is closely associated with a distinctive perspective on historical development. Essentially, through focusing on historical events, this not only permeates an understanding of the ‘value’ of a particular policy outcome, but also the order in which the outcomes occurred. At a foundational level, the significance of focusing on historical events was also echoed at an initial level by Max Weber, who stated that politics and society run on ‘tracks’ that are laid down at critical moments in a country’s history. On this stance, Weber acknowledged that while occasionally new ideals emerge that aim to transform the terms of struggles in societal interests, individuals and groups nevertheless pursue their interests along established tracks laid down by existing political institutions (1946, cited in Ikenberry, 1994: 1). Therefore, the identification of path-dependence involves a process of tracing a given outcome back to a particular set of historical events. Additionally, path-dependence also denotes how events are themselves contingent occurrences that cannot be contemplated on the basis of prior historical causation. This proves to be a central premise in determining the significance of path-dependency as a means of understanding political and social outcomes. As Fritz Scharfp (1997: 29) puts it;

“[I]n a world that is exceedingly complex and in which we often be studying unique cases, we must have a fair idea of what to look for if we wish to discover anything worthwhile. Since a
single data point can be “explained” by any number of regression lines, post hoc explanations are too easy to invent and usually (unless invented with the skill of the master historian) totally useless. The implication is that our search for explanations must be disciplined by strong prior expectations and that we must take the disconfirmation of such expectations as a welcome pointer to the development of more valid explanations.”

3.3.3 Conceptualising ‘path-dependency’ in sociology and politics.
In defining path-dependency conceptually, historical sociologists have derived a rather broad conceptualisation which essentially enshrines the argument that ‘past events influence future events’. (Mahoney, 2000: 510). According to Sewell, this means “that what has happened at an earlier point in time will affect the possible outcomes of a sequence of events occurring at a later point in time” (1996: 262-63). From this stipulation then, the process of path-dependency demonstrates how the decisions made in the past persist into the present and shape the alternatives for the future (Karl, 1997: 11). In breaking down this definition further, the theoretical construct of path-dependency has been depicted by Mahoney (2000: 510-11) as having three defining features: firstly path-dependent analysis places significant emphasis on events which occur ‘earlier’ in an historical trajectory of policy evolution; secondly during the course of the path-dependent sequence, early historical events are ‘contingent’ occurrences and thus cannot be explained on the basis of prior events; thirdly, once a contingent occurrence takes place, the path-dependent sequence becomes marked and institutional ‘inertia’ occurs. This implies that once a process is set into motion and begins to track a specific outcome, this becomes a continuous policy trajectory moving forward. These defining characteristics shall form the basis for the analysis of path-dependency as a theoretical process below.

3.3.4 Self-reinforcing sequences and the process of ‘increasing returns’.
From the conceptual definitions above, it is apparent that the theoretical framework of path-dependency facilitates a contemplation of how ‘institutions’ structure a nation’s response to new challenges. Pierson (2004) posits that the role of historical events in the shaping of political and social outcomes can be specified by three historical effects: increasing returns and path dependence; the role of timing; the sequence; and attention
to long terms processes. Within the realm of politics, Immergut and Anderson (2008: 354) have stated that due to the very nature of politics; with its desire for collective action; institutional constraint on behaviour; scope for political authority and power asymmetries; and lack of both transparency and mechanisms for restoring efficiency such as for instance competition and learning; entails that the political sphere is laden with opportunities for path-dependency. In terms of highlighting the significance of conceptualising these ‘paths’ in institutionalist analysis, Pierson points out that each step down a particular path produces consequences that increases the attractiveness of that policy direction (2004: 18). Hence, as such effects begin to accumulate; they generate a powerful cycle of self-reinforcing activity (Pierson, 2004: 18).

By implication, this highlights that the concept of path-dependency enshrines a ‘positive feedback’ mechanism, which as Brian Arthur points out has a number of distinctive features such as;

1. **Unpredictability.** Because early events have large effects and are partly random, many outcomes may be possible. We cannot predict ahead of time which of these possible end-states will be reached.

2. **Inflexibility.** The farther into the process we are, the harder it becomes to shift from one path to another. In applications to technology, a given subsidy to a particular technique will be more likely to shift the ultimate outcome if it occurs early rather than later. Sufficient movement down a particular path may eventually “lock-in” one solution.

3. **Nonergodicity.** Accidental events early in a sequence do not cancel out. They cannot be treated (which is to say, ignored) as “noise”, because they feed back into future choices. Small events are remembered.

4. **Potential path inefficiency.** In the long run, the outcome that becomes established may generate lower payoffs than a foregone alternative would have. The process may be path inefficient (1994, summarised in Pierson, 2004:18).

In this regard, these characteristics highlight the significance of sequencing events, as different sequences may produce divergent outcomes. As earlier events matter much more than later ones, this highlights that the processes of accounting for the historical context matter.
3.3.5 Tracing the evolution of ‘path-dependency’ analysis in the disciplines of economics and technological development.

Academic scholars in the discipline of economics have proven to be stalwarts in the development of theoretical frameworks on path-dependency and explaining how decisions made in the past influences the present and the future. In terms of characterising the process of ‘self-reinforcing sequences’, scholars in economics have derived the term of ‘increasing returns’ to denote how the probability of further steps down a specific path increases with each successive move down that path until an ‘equilibrium’ point is attained (Mahoney, 2000: 512). In essence, the goal of achieving a unique equilibrium is compatible with institutionalism and the theoretical construct of path-dependency because it suggests a world of potential predictability and efficiency (Pierson, 2004: 22). On a wide range of topics, such as the development of international trade, causes of economic growth and the emergence of modern technologies, path-dependence or in the case of economics ‘increasing returns’ arguments, have gained significant prominence. A central reason for this is due to the environment being complex and knowledge intensive (Arthur, 1994).

As a consequence, this entails that an early edge, such as a technological development, may trigger positive feedback that ‘lock-in’ the use of a particular technology, and in the process excludes competitors, even if not necessarily the most efficient in the long-run. Therefore, with the concept of increasing returns, actors have strong incentives to focus on a single alternative and to continue down a specific path once initial steps are taken in a specific direction (Pierson, 2004: 23). This form of path dependence argumentation has been applied to the success of the “QWERTY” typewriter keyboard over the Dvorak design despite it being less efficient, the battles between Betamax and VHS video recorders and DOS-based and Macintosh computers (Pierson, 2004; Mahoney, 2000; Wilsford, 1994).

3.3.6 Transition from ‘economics’ to ‘politics’ in path-dependency analysis.

In comparison to economics, the sphere of politics differentiates in a number of different ways. However, Pierson points out that there are similarities between the two disciplines which are most relevant when contextualising the sources and consequences of path-
dependence. As such, it is posited that there are four interconnected aspects of politics that make this realm of social science susceptible to the process of positive feedback. These are as follows: the central role of collective action; the high density of political institutions; the possibilities for using political authority to enhance asymmetries of power; and its intrinsic complexity and opacity (2004: 30). By comparison to the discipline of economics, there is however a significant difference regarding the impact of path-dependent forces in the political sphere. As Liebowitz and Margolis (1995) have highlighted, economic systems are ineffective in offsetting path-dependent processes in politics. Pierson (2004: 30) demonstrates that this is due to there being three characteristics within the political sphere which reinforce institutions, which are: the absence or weakness of efficiency-enhancing mechanisms of competition and learning; the shorter time horizon of political actors; and the strong status quo bias generally built into these political institutions. The existence of these features in politics have the effect of making the process of positive feedback in politics particularly intense as they increase the difficulty for political actors to reverse the policy direction which has been established.

In contemplating further the features of path dependency in the political sphere, it is important to firstly highlight a fundamental feature in politics, which is its focus on the provision of public goods. As such, much of the issues of concern to political scientists centre on the coordination efforts of political actors in their quest for public goods that require ‘formal’ institutions. Upon being established, these formal institutions instil constraints which are applicable to all political actors through legislative forces. Furthermore, politics also represents a study of authoritative struggles in attempting to establish, enforce and change the rules governing a particular territory. Hence, it represents a process of wielding authority in an environment through which formal institutions (such as constitutional rules) and public policies place extensive and legally binding constraints on behaviour (Pierson, 2004: 34).

In terms of defining public goods, Pierson points out that “[s]uch goods are distinguished by jointness of supply (where the production costs for the good are unaffected or only modestly affected by those consuming it) and nonexcludability (where it is very costly or impossible to limit consumption to those who have not paid for a good) (2004: 31). Therefore, public goods include for instance national defence, environmental protection, street lighting and so on, which in effect cannot be provided through the market.
While it is evident that ‘policies’ may be more easily altered than the ‘constitutive rules’ of formal institutional structures. They nevertheless form a predominant ‘constraint’ element within the political environment. As the policies that come to be grounded in law and backed by the coercive power of the state, signal to political actors what policies need to be delivered in a societal context and also establishes the rewards and penalties attached to conducting particular activities. Therefore, most policies are presented as a durable feature in the political landscape. This is particularly pertinent in the context of modern societies whereby widespread policy arrangements fundamentally shape the ‘incentives’ and ‘resources’ of political actors within this sphere (Pierson, 2004: 35).

In the context of path-dependent analysis, the conceptualisation of public policy and institutionalism demonstrates that the ‘self-reinforcing’ processes make reversals increasingly unattractive over a period of time. As the creation of new institutions and policies often generate high ‘fixed costs’, ‘learning effects’, ‘coordination effects’ and ‘adaptive expectations’. Additionally, the establishment of new institutions and policies require individuals and organisations to invest in specialised skills, deepened relationships with other organisations and the development of particular skills and identities. Hence, these activities serve to increase the attractiveness of maintaining the existing institutional arrangements relative to a proposed alternative. Therefore, within the confines of an institutional dense environment, this attests that the initial actions on a policy initiative have the effect of constraining a policy actor’s behaviour onto ‘paths’ which in the ‘long-run’ are difficult to reverse. From this conceptualisation, the theoretical core of path-dependency becomes realised when social/policy actors make commitments based on existing institutions and policies (Pierson, 2004: 35).

3.3.7 Critical Junctures and the sequencing of events along a path-dependent trajectory.
The theoretical construct of critical junctures has also proven to be an essential building block in the historical institutionalist school of thought. As such, it is postulated that a dual model of institutional development characterised by relatively long periods of path-dependent institutional stability are punctuated occasionally by brief periods of
institutional flux – referred to as critical junctures – during which dramatic change is possible. The central premise of such arguments accentuates the lasting impact of choices made during those critical junctures in a nation’s history. Essentially, these choices have the effect of closing off alternative options which in turn leads to creating institutions that generate self-reinforcing path-dependent processes (Cappoccia and Kelemen, 2007: 341). As Mahoney (2000: 513) summates below;

“Critical junctures are characterized by the adoption of a particular institutional arrangement from among two or more alternatives. These junctures are ‘critical’ because once a particular option is selected it becomes progressively more difficult to return to the initial point when multiple alternatives were still available.”

The concept of the ‘critical juncture’ has also been depicted as being ‘counterfactual’; this involves investigators imagining an alternative policy option being selected and accordingly attempt to rerun history. In terms of selecting a path-dependent trajectory, the selection of a particular policy trajectory is marked by ‘contingency’. This implies that it is impossible, in theoretical terms, to explain or predict, in a determinant or probable sense, the occurrence of a specific outcome. Hence, a contingent event is one which was not expected to take place (Mahoney, 2000: 513).

In Figure 3.1 below, the concept of ‘contingency’ is demonstrated within a path-dependent self-reinforcing sequence. In this illustration three options; A, B and C are available at Time 1. Based on the initial conditions present at that time and premised on one or more explanatory theories, the eventual adoption of option B cannot be foreseen or explained. In taking into consideration the initial conditions and theoretical understandings of causal processes, history could hypothetically re-run many times. This highlights that there would be no reason why option B could be implemented above that of alternative options. Therefore, upon the initial adoption of B during the critical juncture period – in Time 2 – this makes it a ‘contingent’ occurrence. Furthermore, as option B is the selected option – as Time 3+ suggests – it is stably produced across time into the future (Mahoney, 2000: 514-15).
The illustration above depicts a ‘functionalist’ interpretation of institutional reproduction. Under this method, the institution is reproduced because it serves a function within the overall system. This could be in consequence to the necessitation of integration and/or adoption and survival for a larger system within which the institution is embedded (Mahoney, 2000: 517-19). Furthermore, in this instance the process of change or reproduction occurs in response to an ‘exogenous’ shock which interrupts existing processes and opens the system for radical reorganisation. This relates to critical junctures in which historical windows of opportunity arise through the conjuncture of various internal forces that in an individual sense were not capable of generating change but as a collective make radical change possible. From this standpoint, the notion of a critical juncture is premised on a belief that history leans towards an ‘equilibrium order’ (Sitek, 2010: 574-75). It is also important to note in this context, that path-dependent analysis, within the theoretical confines of ‘functionalism’, does not account for the origins of that institution, which is primarily due to the element of ‘contingency’ explained above. Rather the role of functionalism is to identify predictable self-reinforcing and reproduction mechanisms (Mahoney, 2000: 517-19). This takes the form of a conceptualised pattern, as Mahoney (2000: 519) points out in terms of identifying how;
“...the institution serves some function for the system, which causes the expansion of the institution, which enhances the institution’s ability to perform a useful function, which leads to further institutional expansion and eventually institutional consolidation.”

3.3.8 The role of power and asymmetrical relations in institutional persistence and change.

The concept of power and asymmetrical relations of power also play a significant role in explaining institutional continuity and reproduction. Within the historical institutionalist perspective, the primary interest is in the manner in which institutions distribute power unevenly across social groups. This perspective places less emphasis on scenarios which reflect free-contracting individuals. On the contrary, they are more likely to assume a world through which institutions give some groups or interests disproportionate access to the decision-making process. Therefore, rather than emphasise the degree to which an outcome makes an individual better off, they tend to stress why some groups lose while others win (Hall and Taylor, 1996: 941).

In the context of self-reinforcement within a power centred approach, Mahoney argues that an institution can persist in spite of most individuals or groups who prefer to change it (Mahoney, 2000: 521). Thus, if an ‘elite’ group benefit from the existing arrangements, it has sufficient power to promote its reproduction. The process through which this occurs in path-dependent analysis is reflected by Mahoney (2000: 521) who states that;

“[o]nce the institution develops … it is reinforced through predictable power dynamics; the institution initially empowers a certain group at the expense of other groups; the advantaged group uses its additional power to expand the institution further the expansion of the institution increases the power of the advantaged group; and the advantaged group encourages additional institutional expansion. Because early events are contingent, this sequence of empowerment can take place even though the group that benefits from the institution was initially subordinate to an alternative group that favoured the adoption of a different institution.”

As such, path-dependent analysis provides an understanding of how institutions alter the power structures in society through strengthening previous subordinate actors at
the expense of previously dominant ones. Thus, it is assumed, through the conceptual framework of power, that institutional reproduction is a process of conflict in which significant groups are disadvantaged by an institution’s persistence. The existence of ‘conflict’ suggests that the dynamic of potential change is in-built within institutions in a similar manner to the dynamic of self-reinforcement, which also represents a defining characteristic of an institution. In this sense, power-based institutions are considered to reproduce themselves until they reach a critical threshold, after which self-reinforcement becomes untenable due to the inherent conflictual aspects of the institution eventually leading to institutional change. For instance, in an empirical context, the element of change could occur after which the reproduction of an ‘elite-supported institution’ disadvantages the subordinate groups to the point that these groups challenge the prevailing orthodoxy of the institutional arrangements. Furthermore, the process through which the institution empowers an elite group may become a source of division for that group. Consequentially, this could facilitate a transformation of existing arrangements. Therefore, from this interpretation of a power-centred approach to institutions, an interesting interpretation can be derived in respect to explaining the ‘continuity’ of an institution as well as its ‘eventual demise’ (Mahoney, 2000: 521-23).

3.3.9 Path-dependent analysis and health care reform.
In the context of health care reform, Sitek (2010: 570) argues that one of the major strengths of the new institutionalist perspective is that its analytical focus provides an integrated view of a health care system. Within the framework of historical institutionalism, its emphasis on the importance of complementarities in the different segments of institutional order and the role of change is particularly useful in health care studies. As such, it enables the analysis to move away from a narrowly understood political arena and view the policy process in the context of interdependencies between the state and the political system and the complex structures of organisations and vested interests within the health care sector (Sitek, 2010: 570).

Häkkinen and Lehto (2005) argue, in analysing the evolution of the Finnish health care system, that there are some elements of institutionalism theory evident. This is particularly pertinent regarding the concept of path-dependency where it is argued
that: the tradition of strong yet small local authorities and the lack of legitimate regional authorities; the coexistence of a dominant Beveridge-style health system and marginal elements of Bismarckian social insurance; have been significant in explaining the course of evolution in Finnish health care provision. As such, the elements of path-dependency is prevalent through the upholding of the National Health Insurance (established in 1964) and the continuance, within its finance structure, to reduce the temptation for ‘privatisation’ and ‘marketization’ in health care provision. In fact, it was stated that successive governments in Finland over the past few decades demonstrated no desire to alter the National Health Insurance model. Furthermore, despite the deep economic recession of the early 1990’s, the institutionalist theoretical perspective of path-dependency was prevalent in that the downturn appeared to have strengthened the continuity of the well-established political consensus with regards to the traditional health care model of social provision (Häkkinen and Lehto, 2005: 92-3).

Similar to the Finnish case, academics have also identified traces of path-dependency in respect to the National Health Service (NHS) in operation in the United Kingdom (UK). During her tenure as Prime Minister, Margaret Thatcher sought to transform the very logic which the NHS came to represent in British society. As such, the 1991 reforms introduced by the Thatcher government set out to introduce effective policy changes that would see a separation between the ‘purchasers’ and ‘providers’ of health care services. Essentially, this was to be accomplished through: the establishment of fund holding general practitioners (GP); a system of district health authority (DHA) contracts with hospitals; hospitals set up through autonomous trusts and hospital consultants (hospital specialists) by way of negotiated contracts with hospital trusts. The primary motivation behind this reform agenda was to create a mechanism that would induce competition among providers – hospitals and consultants – for the business of purchasers – the fund-holding GP’s and the DHA’s. This was to achieve more efficiency in the provision of more health care services for the money spent (Wilsford, 1994: 265).

Despite the creation of an ‘internal market’ of competition amongst providers of health care services and the backdrop of Thatcher’s neo-liberal ideology during this period, there were nevertheless constraints placed on policy actors to sustain the path-dependent trajectory established with the introduction of the NHS in 1948. As such, the
institutional system ‘reinforced’ core elements which make up health care provision namely: health care free at the point of delivery; universal; and comprehensive. Attempting a change to this structure, would risk enormous political unpopularity amongst the public and the media. Therefore, this placed a significant constraint on the reform achievable due to the staunch resistance against proposals that sought to ‘privatise’ or ‘dismantle’ the NHS structure of social provision (Greener, 2002: 176-77). Hence, the overall ethos of the NHS remained through, its deep embedment, on a path-dependent trajectory established in British health care policy.

3.4 Sociological Institutionalism.
Similar to the historical institutionalist perspective, the sociological institutionalist school of thought owes its origins to the late 1970’s mainly as a sub-field to organisational theory (Schmidth, 2006: 107). Furthermore, sociological institutionalism also rejected the older methodological approaches in political science, such as behaviouralism and rational choice analysis. The scholastic movement that emerged was reflective of a time when academics within the sociological field began to critically analyse the traditional conceptions drawn between those aspects of the social world which are said to reflect the formal means-ends of ‘rationality’, that are commonly associated with organisational/bureaucratic structures, against those aspects of the social world which are depicted as displaying a diverse set of practices associated with ‘culture’ (Hall and Taylor, 1996: 946).

As such, it was against the Weberian assumptions pertaining to ‘rationality’ and ‘efficiency’ of organisations that led scholars in sociological institutionalism to draw attention to the forms and procedures of organisational life stemming from culturally-specific practices. Sociological institutionalists’ analysis thus came to be synonymous with an understanding of institutions which encapsulated the norms, cognitive frames and meaning systems that guided human action. Hence from this standpoint, rationality for sociological institutionalists is socially constructed and both culturally and historically dependent. Additionally, it is defined as those cultural institutions which effectively set limits on the imagination of actors. This in turn creates basic preferences and identities whilst setting the context within which purposeful, goal-orientated action
is deemed acceptable according to a ‘logic of appropriateness’. This is in stark contrast to rationalist views of human behaviour which follows a ‘logic of interest’ and does not account for the impact of the institutional environment in shaping individual action (Schmidt, 2006: 107).

3.4.1 Sociological institutionalist definition of institutions.

Peters (2012: 127) argues that the ‘new’ institutionalism variant of sociological institutionalism has set a particular niche as a theoretical approach. That is, it can succinctly explain the process of creating institutions than just outlining the features of the institutions which result from that process (2012: 127). This is in contrast to the main-stream discipline of political science, whereby scholars tend to explain the effects of institutions as opposed to the creation or dissolution of institutional structures. For most political scientists, the central reason for analysing institutions is to derive an understanding of how the structures shape public policies or influence other fundamental political processes. Whereas for sociological institutionalists’ the primary interest of theorists is in the ‘existence’ of the institutions, their ‘internal processes’ and their ‘relationships’ with other institutions in the field (Peters, 2012: 128).

In terms of providing a conceptual definition of institutionalism, sociological institutionalists’ tend to be concerned with the process of creating values and cognitive frames within an organisation than with the end-state. As Scott (1995: 33 cited in Peters, 2012: 137) defines;

“Institutions consist of cognitive, normative, and regulative structures and activities that provide stability and meaning to social behaviour.”

This represents a broad definition of institutions which encapsulates both structural and cognitive features in sociological institutionalism terms. Jepperson (1991: 149) extends this definition further where institutions are defined as;

“socially constructed, routine produced …program or rule systems … operating as relative fixtures constraining environments and …accompanied by taken-for-granted accounts.”
Hence, institutions are defined in a normative sense reflecting the constraint mechanisms existent in the internal environment.

3.4.2 The significance of ‘culture’ within sociological institutionalism theory.

It is prevalent that culture holds a considerable influence in respect to shaping the scope and future direction of institutional organisations. In this regard, the new institutionalist approach within the discipline of sociology began to interpret institutional forms and procedures being utilised in modern organisational systems not because they viewed these practices as being the most efficient means of delivering a particular outcome. Rather, sociologists within this new institutionalist approach are primarily interested in the formal rules and procedures which exist within an institutional setting. The central reason for this is that these formal rules and procedures are thought to be derived from culturally specific practices, akin to the myths and ceremonies devised in society, that ultimately come to be assimilated into the institutional organisation. Therefore, the attribute of utilising a ‘cultural’ framework is not concerned with analysing the achievement of the formal ‘means-ends’ of efficiency but rather with the transmission of cultural acts in more general terms (Hall and Taylor, 1996: 946-48). In this sense, the discipline of sociological institutionalism articulates that a reflection of the ‘environmental’ context through which an institution operates must be examined in cultural terms.

In contemplating the significance of culture in evaluating the functioning of institutions, the literature highlights that a definitive analysis must be undertaken regarding the key factors which come to symbolise existing institutions. As Meyer and Rowan points out, the formal structures of many organisations during the post-industrial era dramatically reflected the cultural myths of their institutional environments rather than the actual demands of their work activities (1991: 43). Thus, it is deemed important when analysing the manner in which culture is reflected in the institutional environment to draw a distinction between the formal structures of an organisation with that of its daily activities. Essentially, the formal structure of an organisation represents a blueprint for activities which includes the configuration of the organisation such as a listing of offices; departments; positions and programs. Additionally, these elements are also
linked by the explicit goals and policies that come to represent a rational theory of how and to what extent activities within an institution can be linked together (Meyer and Rowan, 1991: 42-43).

However, the assumption suggesting that organisations perform according to their blueprints is not valid. As Meyer and Rowan depict, within an institutional organisation a gap exists between the ‘formal’ and ‘informal’ attributes. This entails that the structural elements that form an institutional organisation are often loosely linked to each other and to activities – for instance rules come to be violated, decisions are often unimplemented or if implemented have certain consequences. Therefore, this gives rise to the informal mechanisms for dealing with occurrences which are contrary to the formal blueprint laid down from the outset (Meyer and Rowan, 1991: 43).

3.4.3 Assessing the impact of prevailing cultural norms and values on the institutional environment: the practice of ‘institutional isomorphism’.

The significance of cultural attributes is also relevant within contextualising the institutional environment. In this sense, the institutional organisation is essentially structured by phenomena in their environments and tends to become isomorphic15 with them. This implies that the formal structures of an organisation matches the institutional environment through both technical and exchange interdependencies. Furthermore, the parallelism that exists between institutional organisations and the cultural environment can be found in the premise that an organisation’s structure to a large extent reflects socially constructed reality (Berger and Luckmann, 1966 cited in Meyer and Rowan, 1991: 47).

In terms of defining the impact which prevailing cultural attributes instil into the institutional environment, Meyer and Rowan (1991: 49) point out that the premise of;

“[i]somorphism with environmental institutions has some crucial consequences for organizations:
(a) they incorporate elements which are legitimated externally, rather than in terms of efficiency;
(b) they employ external or ceremonial assessment criteria to define the value of structural

15 The term isomorphic has been defined as “being of similar, form, shape or structure” (Merriam Webster, 2015).
elements; (c) dependence on externally fixed institutions reduces turbulence and maintains stability.”

The cultural environment is thus depicted as holding a significant impact on the structures of an institutional environment. Essentially, this is based on the theoretical premise that the success and survival of an organisation rests on institutional isomorphism; the incorporation of externally legitimated formal structures which has the effect of enhancing the commitment of ‘internal’ participants and ‘external’ constituents to the institutional organisation. Hence, through applying an external assessment criterion, this enables an institutional organisation to remain successful by social definition which in turn makes it difficult to fail\(^\text{16}\) (Meyer and Rowan, 1991: 49).

It is evident when analysing the formal structures of institutions that the practice of demonstrating ‘awareness’ to external factors, such as cultural norms and social constructions plays a crucial role in determining the survival of an organisation. As Meyer and Rowan argue, in designing a formal structure which adheres to the prescriptions of myths\(^\text{17}\) accustomed to the institutional environment, an organisation effectively demonstrates to the general populace that it is acting on collectively valued purposes in a proper and adequate manner (1991: 50). Thus, awareness of external factors proves to be detrimental in providing legitimacy to an institutional organisation as a means of securing its support and survival. Furthermore, another aspect which demonstrates the impact of the cultural environment is the ‘evolution of organisational language’. This is reflective of where the labelling of an organisational chart as well as the vocabulary used in the delineating of organisational goals, procedures and policies are analogous to the vocabularies or motive utilised to account for the activities of

\(^{16}\) Within institutional environments, organisations become sensitive to and employ external criteria of worth which contributes to the legitimacy of functioning institutional organisations (Meyer and Rowan, 1991: 51).

\(^{17}\) The term ‘myth’ in this context refers to factors which generate the formal organisational structure. In essence, the concept has two underlying properties. As Meyer and Rowan point out, “[f]irst, they are rationalised and impersonal prescriptions that identify various social purposes as technical ones and specify in a rule like fashion; the appropriate means to pursue these technical purposes rationally (Ellul 1964 cited in Meyer and Rowan, 1991: 44). Second, they are highly institutionalised and thus in some measure beyond the discretion of any individual participant or organisation. They must, therefore be taken for granted as legitimate, apart from evaluations of their impact on work outcomes.” (1991: 44).
individuals. In sum, through the existence of cultural norms and socially constructed realities, there is a perception amongst members in society of how certain responsibilities will be carried out regardless of the individual conducting such tasks (Mayer and Rowan, 1991: 50).

It is prevalent that the sociological literature within institutionalism theory is also concerned with how the members of an institution perceive an arising situation in a structural setting and the ‘frames’ that they bring to fruition on those situations in order to make decisions about them (Berger and Luckmann, 1967 cited in Peters, 2012: 133-34). In this sense, the ‘cognitive’ concept within sociological institutionalism places greater emphasis on ‘perceptions’ rather than ‘evaluations’. This is distinguishable from ‘normative’ conceptions; due to ‘cognitive’ analysis placing more significance on how members of an institution interpret data from their environment. By comparison, the ‘normative’ construct focuses on how the institutional environment instructs a member of an institution on the use of appropriate behaviour in a given situation (Peters, 2012: 134). Despite the subtle difference between the two perspectives, both constructs are needed to give a complete explanation of institutional behaviour (Scott, 1995 cited in Peters, 2012: 134). As the logic of one perspective affects individuals of an institution due to their receiving of ‘inputs’ on which they make decisions while the other segment of the sociological process imparts on explaining how decisions come to be made (Peters, 2012: 134).

3.4.4 Conceptualising the ideal of cultural persistence in sociological institutionalism theory.

In terms of examining how cultural values and ‘normative’ and ‘cognitive’ frames become a fixed feature in institutional organisations, Zucker argues that the persistence of these attributes rests on three theoretical characteristics which are: cultural transmission; maintenance; and resistance to change. The concept of ‘cultural

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In contextualising this further, in the same essence as jealousy, anger, altruism, and love are myths that interpret and explain the actions of individual persons, the myths of doctors, accountants, or the assembly line explain organisational activities. This in turn reflects a notion that with the existence of formal structures or myths it will be possible to demonstrate, for instance that engineers will solve a specific problem or that secretaries will perform specific tasks without knowing exactly who these engineers or secretaries will be or what exactly they will do (Meyer and Rowan, 1991: 50).
transmission’ ascertains that for cultural persistence to occur, transmission must take place from one generation to the next. Essentially, Zucker establishes two theoretical approaches to institutionalisation; the ‘traditional’ institutionalist perspective and the ‘ethnomethodological’ perspective (1991: 83-85).

The primary focus of the traditional institutionalist approach is on the normative aspects of institutional organisations, which persist due to norms being shared. This contends that no external motivational forces for conformity are necessary as norms, which are central for institutions, develop to become internalised. Additionally, the traditional approach to institutions also focuses on an actor’s compliance with an action prescribed by an institutional setting. As such, the motivation of actors to comply to institutional norms is part of the recognition of functional necessity, self-necessity, or internalisation. Hence, under this conceptualisation an actor plays no independent role in sustaining these institutions; rather their behaviour is constrained to act in accordance with the institutional norms. Moreover, the social structure at the macro level determines the behaviour of individuals and small groups at a micro level (Zucker, 1991: 84).

The ethnomethodological perspective provides a distinctive approach in that it encapsulates the role played by institutions in the practice of cultural persistence, through dealing specifically with institutionalised action. Thus, reality, while being socially constructed, is experienced in an ‘intersubjective world’ which is known and knowable in common with other individual actors. Furthermore, the existence of this socially constructed reality occurs historically prior to the actors obtaining their function within an institutional environment and contains its own resistant objective structures (Zimmerman and Pollner, 1970: 37 cited in Zucker, 1991: 85). Therefore, it is attributable that this form of socially constructed reality effectively constrains the action of policy actors in a generational sense – due to shared cultural norms and practices defining what is reality for policy actors (Zucker, 1991: 85).

With regards to defining how this social constructed reality survives the test of time, this occurs through the daily functioning of policy actors. Essentially, each actor perceives and describes social reality through enacting it and in the process transmits it to other actors in the social system (Berger, 1968 cited in Zucker, 1991: 85). The practice of generational transmission provides a succinct analysis of how this process
unfolds\textsuperscript{19}. Through the process of institutionalisation, individual actors transmit what they perceive to be socially conceptualised as real and as a more or less taken for granted part of social reality. Thus, institutional acts must be perceived as being both \textit{objective} and \textit{exterior}. An act is objective when it has the capacity to be potentially repeatable by other actors without altering the common definition of the act. Acts are exterior when their subjective understanding is reconstructed into an intersubjective contemplation. This creates a perception that these acts are part of the external world. As such, the theoretical variables of objectification and exteriority operate in parallel, which entails that an increase in one variable leads to an increase in the other. Additionally, the degree to which an act is institutionalised is to a significant extent dependent on these two variables. Therefore, this implies that acts may vary in the degree to which they are institutionalised (Zucker, 1991: 85).

In the event of acts having ready-made institutional structures, they are institutionalised, that is they are both objective and exterior. Thus, the existence of ready-made institutional structures will not occur for acts which are unique to a particular actor or for acts which are low on intersubjective knowledge. While institutional structures are socially created, they nevertheless function as objective rules because their social origin is ignored. Despite this, the ready-made institutional structures define what is possible; hence institutionalisation makes coherent what is rationally obtainable in an objective sense. This entails that direct social control, through the inclusion of incentives or negative sanctions, are not necessary due to the objective ethos of the institutionalising process. In this regard, application of such sanctions to an institutional structure may have the effect of deinstitutionalising the objective intent of the act. Moreover, the application of negative sanctions may also have the effect of making the overall intent of the institutionalising act less objective, less impersonal and less factual in outlook (Zucker, 1991: 85-86).

\textsuperscript{19} For instance, in taking the example of the generational transmission in the context of the family, the young are enculturated by the previous generation and in turn enculturate the next generation. In addition, the grandparents are not required to be present to ensure the adequate transmission of this general cultural meaning. Therefore, each generation effectively hold the belief that it is describing what is objective reality (Zucker, 1991: 85).
By implication then, there is a significant emphasis placed on the meaning of an institutional act in terms of whether or not it can be perceived as being more or less exterior and objective. This to a significant extent depends on the environmental context in which the act is performed in tandem with the role played by a specific actor. For instance, acts which are ‘dependent’ on a specific actor are low on institutionalisation. By contrast, an act which is ‘performed’ by an actor occupying a specified occupation or role is high on institutionalisation. Hence, the degree to which an act is highly institutionalised is dependent on how stringent the formal and informal rules are in shaping the institutional environment of an organisation and also the influence of individual policy actors, which according to this theoretical perspective should be minimal (Zucker, 1991: 86)\(^\text{20}\).

### 3.4.5 Consequence of the ethnomethodological approach within sociological institutionalism: the impact of cultural transmission.

The central argument to be derived in relation to the practice of cultural transmission is that when acts are highly institutionalised, transmission occurs in a routine manner. This rests on the premise that the actor conducting the transmission simply communicates these cultural norms as objective fact, and the actor receiving this social knowledge treats them as an accurate depiction of reality. However, the degree of institutionalisation evident in an organisation also determines the success of cultural transmission. For instance, when transmission occurs through personal influence, this has the overall effect of reducing the level of exteriority and objectification practiced within an organisation in the performance of tasks. Therefore, this contends that if there is an absence of personal influence amongst actors in an organisation, the theoretical

\(^\text{20}\) In the context of the actual tasks performed, any act which is performed by the occupiers of an office is seen as being highly objectified and exterior (Zucker, 1991:86). This suggests that when an actor occupies an office, acts are to a large extent seen as impersonal and as continuing over time, across different actors (Hughes, 1937 cited in Zucker, 1991: 86). Furthermore, an office enhances the already existing intersubjective knowledge of appropriate action. Hence, both the position and the role of the occupant establishes conditions which effectively maximise the treatment of any act as an accurate reflection of ‘social reality’ or as a ‘fact of life’. Therefore, in evaluating the tasks which are performed by occupants of an office, it can be determined the degree to which the formal act has been institutionalised, though the degree of such institutionalisation may vary (Zucker, 1991: 86).
premises of exteriority and objectification dictates that cultural transmission will be significantly increased (Zucker, 1991: 87).

The process of continuity in the transmission process also increases institutionalisation. That is, the more historical evidence which suggests that the transmission process is known, the enhanced degree of continuity the actors assume. Furthermore, the history of transmission also provides the foundation for the assumption that the meaning of a specific act is part of an intersubjective common-sense world. In this sense, as the process of continuity increases, the acts in turn become increasingly objectified and made exterior to the particular interaction (Zucker, 1991: 87).

In turning to the second attribute of cultural persistence, maintenance, the basic assumption is that transmission of acts high on institutionalisation is sufficient for maintenance to occur routinely with regard to these same acts. As described above, in some instances the degree of cultural transmission is very much dependent on the presence of ‘exteriority’ and ‘objectivity’. This as a consequence depicts the degree to which the formal act was institutionalised and also determines the effectiveness of the succession of cultural norms from one actor to the next. In contextualising the practice of maintenance, this reflects a process of social control whereby an organisation low in institutionalisation requires direct sanctions to be imposed to produce compliance (Zucker, 1991: 102). Hence, the principle point to note with regard to maintenance is that the more institutionalised an organisation is, the greater the maintenance without social control.

The third attribute of cultural persistence, which is dependent on the degree of institutionalisation, is resistance to change. This theoretical conception contends that acts which are high on institutionalisation will be resistant to attempts of change through the personal influence of actors. As such, this is due to the acts being viewed as external facts, which are imposed on the setting and, at the same time, defining the contextual environment. Thus, once an act high in institutionalisation is transmitted, attempts to change it through personal influence, will not be successful and may result in the redefinition of the actor, rather than the act itself (Zucker, 1991: 102).
3.4.6 Evaluating the sociological institutionalist approach.

It is evident that the new institutionalist’s perspective in sociology offers a distinctive conceptualisation of the relationship between institutions and individual action. This reflects an attempt to resolve the problem within institutionalism of specifying the relationship between existing institutions and action through associating institutions with ‘rules' to which prescriptive social ‘norms of behaviour’ are attached (Hall and Taylor, 1996: 948). Essentially, this means that actors, who have been socialised into the undertaking of specific institutional practices, internalise the norms associated with these practices, which in turn demonstrates how the process of institutionalisation affects behaviour (Hall and Taylor, 1996: 948). As such, this represents a ‘cognitive dimension’ within the context of institutional impact. Hence, more emphasis is placed on the manner in which institutions influence behaviour through the provision of scripts, categories and models that are indispensable for action. As without them, the behaviour of others cannot be interpreted (Hall and Taylor, 1996: 948) (DiMaggio and Powell, 1991: 83-107). This demonstrates that institutions not only specify what one should do but also specifies what one can imagine doing in a given context. Furthermore, it also contends that institutions do not simply affect the strategic calculations derived by individuals, as stated in the rational choice theoretical framework, but also their most basic preferences and very identity. This highlights that the self-images and identities of social actors are constituted from the institutional environment, which encompasses images and signs provided by social life (Hall and Taylor, 1996: 948).

Hence, sociological institutionalists place significant emphasis on the interactive and mutually constitutive character of the relationship between institutional organisations and individual actors (Hall and Taylor, 1996: 948). As such, this is reflected when an individual engages in socially meaningful acts, and reinforces the convention which they are adhering to. Thus, action is tightly bound up with interpreting existing cultural norms within an institution. Furthermore, the scripts or templates implicit in the institutional environment provide the means for accomplishing the daily tasks which an actor is faced with. From this standpoint, the relationship between an individual actor and the institution is constituted through the process of ‘practical reasoning’ whereby the individual works and reworks the available institutional
templates in an attempt to devise a course of action (DiMaggio and Powell, 1991: 22-24).

3.5 Discursive Institutionalism.

Political scientists have been exploring ‘ideas’ and ‘discourse’ for some time. However the actual term utilised to describe this approach, discursive institutionalism, is of recent origin. While it is evident that a wide range of scholars have used this term (Campbell and Pederson, 2001) or similar derivations such as: ideational institutionalism (Hay, 2001); constructivist institutionalism (Hay, 2006); or strategic constructivism (Jabko, 2006), Schmidt argues that the emphasis has tended to be on the conceptualisation of ideas which make up the discourse rather than on the interactive processes involved in discourse analysis (2008: 304). Thus from this standpoint, the actual term of discursive institutionalism only started to come to prominence through the writings of Vivienne Schmidt (2002; 2008; 2010). At a foundational level, Schmidt argues that discourse stems from the ideals which are generated from what policy actors ‘communicate’ to one another and to the public in a general sense during the course of their attempts to gain legitimacy for policy programs (2002: 169). Thus, through having both a set of ideals about initiating policy change or reform, and an interactive process of policy construction and communication, discourse can create consensus for institutional change within a particular policy area (Schmidt, 2002: 169).

This form of analysis has been applied to a vast range of phenomena, which in turn depends on the construction and interpretation of the ideational and narrative basis of issues. Essentially, one of the central premises espoused by scholars of the discursive institutionalists perspective is that in the process of contemplating the role that ‘ideas’ play in the shaping of public policy, one must understand the entire discourse within which it is embedded. In this sense, the diversion towards a theoretical interest in ‘ideas’ and ‘discourse’ within the field of political science has come to represent the establishment of a ‘fourth new institutionalism’. The theoretical core of discursive institutionalism offers a distinctive perspective to that of the existing institutionalisms: historical; sociological; and rational choice institutionalisms, in that it grants more prominence to issues pertaining to the ideals which mould human behaviour rather than
the structural environments within which individuals function (Schmidt, 2008: 304). This is particularly reflected when characterising the central tenets of discursive institutionalism, as Schmidt describes;

“[p]olitical scientists whose work fits the DI rubric tend to have four things in common. First, they take ideas and discourse seriously, even though their definitions of ideas and uses of discourse vary widely. Second, they set ideas and discourse in institutional context, following along the lines of the three older institutionalisms, which serve as background information. Third, they put ideas into their “meaning context” while they see discourse as following “logic of communication”, despite differences in what may be communicated how and where. Finally, and most importantly, they take a more dynamic view of change, in which ideas and discourse overcome obstacles that the three more equilibrium-focused and static older institutionalisms posit as insurmountable” (2008: 304).

3.5.1 A conceptual definition of ‘ideas’ in institutionalism theory.

In providing a conceptual definition of ideas and the substantive content of discourse, this proves to be difficult as there are a variety of theoretical viewpoints surrounding the concept. Nonetheless, academic commentators such as Goldstein and Keohane (1993: 3) have made a significant attempt at conceptually defining ideas as switches for interests, road maps or focal points. Their central argumentation rests on the premise that ideas can influence policy when the principled or casual beliefs they embody provide road maps. These road maps have the effect of increasing an actor’s clarity about goals or ends-means relationships which both affects the outcomes of strategic situations and becomes deeply embedded in political institutions. This is particularly significant when there is no unique equilibrium. Thus, Goldstein and Keohane essentially demonstrate how ideas matter for public policy, even in the event of individuals behaving in a rational manner to achieve their goals or ends. The central rationale for this sense of dependency is due to such ideas aiding in the clarification and conceptualisation of casual relationships and also in the coordination of individual behaviour. Once

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21 This stems from the belief that rationalist analysis of international politics have often recognised that the assumption of rationality, in the same essence as egoism, is a theoretical simplification of reality rather than a true reflection of it. Therefore, this purports that even in the event of accepting the premise established by scholars within the rational institutionalist school of thought; the actions undertaken by the individual’s depend on the substantive quality of available ideas (Goldstein and Keohane, 1993: 5).
institutionalised, these ideas continue to guide actions in the absence of costly innovation. In this context, the primary focus of scholar’s within this ideational theoretical framework is on how a particular set of beliefs, which are shared by a large number of people, about the nature of their worlds have significant implications for human action (Goldstein and Keohane, 1993: 5).

In conceptualising ideational theory in practice, Goldstein and Keohane derive three overarching types of beliefs which are categorised as: ‘world views’; ‘principled beliefs’; and ‘casual beliefs’. At a foundational level, ideas have the effect of defining a wide range of possibilities for human action. Ruggie argues that the “fundamental modernist concepts such as market rationality, sovereignty, and personal privacy would not have been comprehensible before the development of appropriate terms of social discourse” (1990: 18-20 cited in Goldstein and Keohane, 1993: 8). In this sense, these conceptions of possibility or world views are embedded in the symbolism of a culture and deeply affect modes of thought and discourse. Furthermore, the conceptions also form an individual’s world views that are entwined with people’s perceptions on what constitutes their identities, which in turn evokes deep emotions and loyalties. Therefore, it is the ideals which have the broadest impact on human action which can take the form of world views. A primary example of a world view is the world’s major religious, such as Christianity, which has in a variety of ways deeply affected human social life across millennia (Goldstein and Keohane, 1993: 8).

The theoretical construct, principled beliefs consists of normative ideals that specify a criterion for distinguishing between what is right from wrong and just from unjust22. In addition, principled beliefs are also often justified in the context of larger world views, but those world views are also able to encompass opposing principle beliefs as well23. Nevertheless, the primary function of principled beliefs is to mediate between world views and particular policy conclusions, in the sense that they translate

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22 For instance, the views which express that ‘slavery is wrong’, that ‘abortion is murder’ and that human beings have the ‘right to free speech’ are primary examples of principled beliefs (Goldstein and Keohane, 1993: 9).

23 For example, during times of slavery opponents justified their arguments with reference to Christianity, despite the fact that Christianity had tolerated slavery for almost two millennia (Goldstein and Keohane, 1993: 9).
fundamental doctrines into guidance principles for contemporary human action (Goldstein and Keohane, 1993: 9).

The third analytical tool in this categorisation of ideas is *casual beliefs*. This theoretical construct relates to cause – effect relationships which derives authority from the shared consensus of recognised elites, whether they are village elders or scientists from elite institutions. Essentially, *casual beliefs* provide guides for individuals on how to achieve their objectives. As such, it is evident under the conditions of *casual beliefs* that the efficiency of individual action depends on the support from many people along with the existence of a collection of shared beliefs. In this sense, the central premise of *casual beliefs* relates to the derivation of strategies for the attainment of goals, which are in turn valued because of the existence of shared principled beliefs that are only understandable in the context of broader world views (Goldstein and Keohane, 1993: 10).

### 3.5.2 The concepts of ‘coordinative’ and ‘communicative’ elements in discursive institutionalism.

The theory of discourse analysis represents a more versatile and overarching concept then that of ideas. As the term *discourse* both encapsulates the ‘ideas’ being presented and the ‘interactive process’ within which particular idealisms are conveyed. Hence, the discursive process facilitates an understanding of why certain ideas fail and others succeed through analysing the ways in which they are being projected to whom and where. The representation of ideas and a given discourse then, serve to articulate not only differing levels of ideas or policy, programmatic and philosophical, and different types of ideas (cognitive and normative) but also distinctive forms of ideas such as: narratives; myths; frames; scripts scenarios; and images (Schmidt, 2008: 309). Therefore, as succinctly put by Connolly (1983) the term discourse reflects “institutionalized structures of meaning that channel political thought and action in

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24 For instance, scientific knowledge may reveal how to eliminate small pox or how to slow down the greenhouse effect in the atmosphere. In a similar essence, the Hungarian and Polish revolutions in 1989 demonstrated to the people of East Germany and Czechoslovakia that unarmed mass protest can bring down long-standing repressive governments (Goldstein and Keohane, 1993: 10).
certain directions”, which in turn pattern how arguments are made as well as which ideals come to be represented (cited in Schmidt, 2008: 309).

Furthermore, the concept of discourse analysis not only reflects what individual policy actors articulate on a particular policy matter. On the contrary, discursive institutionalism encompasses a much more complex process of ‘policy construction’ and ‘policy communication’. As such, there are two broad theoretical frameworks utilised when assessing the discourse within which policy decisions are implemented. The first theoretical variant, ‘coordinative’ discourse provides an evaluative framework on how policy actors engage with one another in the derivation of policy. While ‘communicative’ discourse, investigates how policy actors in the process of policy initiation and implementation engage with the wider public within the contextual framework of the necessity and appropriateness of particular policy initiatives (Schmidt, 2008: 310; Peters, 2012: 116).

3.5.3 Coordinative discourse.

In the policymaking environment, coordinative discourse consists of the individuals and groups at the core of policy construction who are in turn responsible for: policy creation; elaboration; and the provision of justification for policy and programmatic ideals. Essentially, this includes policy actors – the civil servants, elected officials, experts, organised interests and activists – who aim to coordinate amongst each other on policy initiatives (Schmidt, 2008: 310). As such, coordinative discourse may occur within the situations where individuals are loosely connected – such as ‘epistemic communities’ in a transnational setting – on the premise of establishing shared cognitive and normative ideals on a common policy initiative (Haas, 1992).

The significance of epistemic communities was highlighted by Haas (1992) who placed particular emphasis on their role in the process of policy making. While the focus is primarily on the international context, it can nevertheless be argued that the same principles highlighted can be applied to the practice of policy making at domestic level. Essentially, Haas demonstrates that at its core, policy coordination encompasses arguments relating to determinism versus free will and also the manner in which the international system is maintained and transformed (1992: 1). As such, one of the
central questions relates to if state policy actors can identify national interest and behave independently of pressures from the social groups they nominally represent (1992: 1).

According to Haas, it is evident that in focusing on the structure of international and domestic power in their explanations of policy coordination, various authors have ignored the possibility that actors can learn new patterns of reasoning and may consequently begin new state interests (1992: 2). Therefore, through recognising that policy decision making encompasses intricacies that involves systematic conditions, knowledge and national action, it is evident that knowledge-based experts – epistemic communities – have the capacity to influence the discourse which a state would follow when confronted with a particular policy problem. Hence, the epistemic community contains roles in the articulation of cause-and-effect relationships of complex problems which enables states to: identify their interests; frame the issues for collective debate; propose specific policies; and identify salient points for negotiation. In this sense, control over knowledge and information proves to be an imperative dimension in facilitating the exercise of power. As the diffusion of new ideals and information can also have the effect of establishing new patterns of behaviour and may prove to be a significant detriment of policy coordination (Haas, 1992: 2-3).

3.5.4 Communicative discourse.

In contrast to the coordinative discourse which occurs in the policymaking sphere, the communicative discourse occurs in the political sphere. As such, the analytical focus is on the individuals and groups involved in the: presentation; deliberation; and legitimating of political ideals to the general public. This encompasses a mass process of public persuasion, whereby political leaders, government spokesperson, policy activists, ‘spin-doctors’ amongst others communicate on policy ideals derived through the coordinative discursive process for public discussion and deliberation (Mutz et al., 1996: 1-17). Furthermore, also included within the communicative discourse are the members of: the opposition parties; the media; analysts; community leaders; social activists;
public intellectuals; experts; think-tanks; organised interests; and social movements (Schmidt, 2008: 310).

The communicative discourse and the public policy initiated in this realm are both directed at and reflective of the demands emanating from the general public – citizens and voters. As citizens of the state, the general public engage in grass-root organising, social mobilisation and demonstrations. Hence, the practice of discursive action stems from the top at governmental action, down to the individual citizen. This is rooted in the premise that it is the policy elites that generate ideas, through which the political elite then communicate to the public. Essentially, political elites often interweave the coordinative and communicative discourses into a master discourse that presents an outline for a coherent political programme. In this context, the master discourse provides a vision of: the stage a policy is at, where it is going; and where it ought to go. This in turn facilitates the political elite’s engagement in a mediation process during the ensuing of public debates. However, in some areas of public policy there may not be an inter-linkage between coordinative and communicative discourses (Schmidt, 2008: 310-11).

3.5.5 Discursive Institutionalism: conceptualising the process of change in the policy arena.

Since the 1980’s, the theoretical landscape of institutionalism has been dominated by the perspectives of historical, sociological and rational choice institutionalisms. While each variant offers a distinctive contemplation of the policymaking process, there is one commonality which binds the recognised ‘new’ institutionalisms together. This relates to how they have proven to be succinct in explaining the process of ‘continuity’ rather

25 In essence, these and other actors are often organised within a policy forum of informed publics (Rein and Schon, 1994) and the “public of organised private persons (Habermas, 1989) as well as within the strong politics of opposition parties, members of the legislature and political commentators (Erisken and Fossum, 2002) which in turn communicate their responses to government policies, engendering debate, deliberation, and ideally, modification of the policies under discussion (cited in Schmidt, 2008: 310).

26 In addition, as members of mini-publics, they express themselves as members of mini-publics; they express themselves in citizen’s juries, issues forums, and deliberate political polls (Goodin and Dryzek, 2006 cited in Schmidt, 2008: 310-11). Therefore, as members of the electorate, the general public’s voices are heard in the opinion polls, surveys, focus groups and of course through the process of general elections, which in this regard, implies that in the field of politics action speaks louder than words.
than ‘change’ in the policy-making process. Therefore, the focus of institutionalism up until this point has been on those attributes which ‘constrain’ rather than ‘enable’ change to take place in the polity arena. In many respects, this represents a point of departure for the new theoretical variant of institutionalism to emerge in recent years, discursive institutionalism. From the onset, this fourth ‘new’ institutionalism aims to go further than the traditional schools of thought in that it observes how change comes to be facilitated through analysing the role of ‘ideas’ and ‘discourse’ within an institutional setting. In succinct terms, the discursive institutionalist perspective aims not only to provide an analytical framework but also gives a commitment to go beyond the rhetoric of ‘politics as usual’ and explain the politics of ‘change’. This process is reflected through depicting: the role of ideas in constituting political action; the power of persuasion in political debate; the centrality of deliberation for democratic legitimisation; the reconstruction of political interests and values; and the dynamics of change in history and culture (Schmidt, 2010: 1-2; Béland, 2005: 1-2).

Thus, the discursive institutionalists’ perspective elevates the theoretical understanding of the policy making process put forward by the historical and sociological institutionalists’ respective schools of thought. As such, the scholars of discursive institutionalism are adamant that this theoretical approach does not dismiss outright the theoretical underpinnings of the earlier institutionalisms but rather treats their body of work as background knowledge in the quest to understanding further, through the conceptual framework of ‘ideas’ and ‘discourse’ analysis, the process of change and continuity (Schmidt, 2010; Béland, 2005).

3.5.6 Conceptualising change and the role of ideas and discourse within historical institutionalism.

In re-surmising the literature on the historical institutionalist school of thought it becomes clear that ‘continuity’ and ‘constraint’ operate as a significant theme within this variant of institutionalism theory. This comes to be reinforced through the theoretical components of the processes associated with ‘critical junctures’, ‘path-dependent forces’ and the institutional ‘norms’ and ‘rules’ which govern the behaviour of policy actors. Therefore, the primary focus of this theoretical variant has been on
explaining how institutional factors such as the relative insulation and centralisation of political elites or the relationship between different branches of government constrain the policymaking process. In this sense, the primary emphasis has been on how ‘institutions’ rather than ‘ideas’ have constrained the art of policymaking. From this contextualisation then, it is prevalent that the proponents of historical institutionalism theory have effectively overlooked the impact of ‘ideas’ in the arena of public policy (Campbell, 1998: 380).

This is evident when delving into the historical institutionalist interpretation of ‘change’ in the policy process. Due to its primary emphasis on the ‘structural variables’ of institutions, this has prevented a clear conceptualisation of ‘policy change’ and also limits the possibilities for a theoretical explanation of change. As Peters et al (2005: 1277), argue there are two overarching problems within this school of thought. Firstly, there is an inherent inability to adequately address political change in its framework. Secondly, there is also a failure to recognise ‘political conflict’ and ‘dissensus’ within what may appear from the outset to be stable, path-dependent time periods. Hence, it is apparent that policy change is presented as being more dramatic and less explicable than it needs to be. (Peters et al., 2005: 1278).

Moreover, there is an evident failure in the historical institutionalist school of thought to account for ‘incremental change’. In this sense, the theory encompasses a deficiency in its tendency to conceptualise change in terms of ‘major events’ rather than the ‘incremental developments’. According to this stipulation, smaller changes in the policy trajectories are ‘defined away’ even in the event of these ‘incremental changes’ cumulatively producing monumental change. This is further evident when analysing the ‘retrospective rationality’ attributes of historical institutionalism theory. Within this conceptualisation, the retrospective features of this theoretical approach contends that scholars tend to only investigate the persistence of ‘victorious’ policy options rather than delving into the complexities and uncertainties associated with the creation of policies – particularly in regards to critical junctures. Therefore, with this inadequacy to conceptualise change, this leads to the disregarding of other significant aspects such as the occurrence of political conflict during both the formative periods of policy development and in the course of a path-dependent trajectory. Essentially, it fails to
explain the process in which a path-dependent evolution of policy is sustained by political factions who fend off all attempts by other actors to offset the course. Hence, historical institutionalism does not encapsulate how political pressures can facilitate incremental change (Peters et al., 2005: 1278).

3.5.7 Identifying core problems in the historical institutionalist perspective of institutional change.

It is evident that the theoretical description of the policymaking process as persisting along ‘well-worn paths’ inhibits an understanding of institutional change. In this regard, Peters et al. (2005: 1282) depict that there are a number of factors which put historical institutionalism as a theoretical approach into question in respect to conceptualising change. While this theoretical approach and path-dependent analysis is theoretically appealing in terms of explaining persistence at one level, it begins to fall apart under more succinct examination. When analysing the ‘historical legacy’ attributes of path-dependent analysis, it is prevalent that institutional arrangements within its structuration do embody ‘principles’ and ‘assumptions’ which constrain later options. However, the historical institutionalist interpretation of institutional durability does not encapsulate how political pressures in the undertaking of social reform in tandem with market forces, both under the remit of ‘ideas’, has given expertise in accounting for potential change. Therefore, the solidity of administrative arrangements can be perceived as being overstated and the role of ‘ideas’ in policy changes as being underestimated, even in the event of those ideas being simply a process of recycling ones influential in earlier periods (Peters et al., 2005: 1287-88)\(^{27}\).

\(^{27}\) Historical Institutionalist theory of persistence and the constraints of institutional structures come to be effectively at odds when analysing the immense institutional change which occurred under the political leadership of Margaret Thatcher within the ideological confines of the New Right ideology of new public management and privatisation. As such, the state-centred and new institutionalist theoretical construction over emphasised the importance of institutions compared to the significant role which ideas contend in the shaping of public policy. Empirically, this comes to light when assessing the influence of neo-liberalism in the shaping of public policy in recent decades. Hence, it is difficult to explain the shift to privatisation and the dismantling of many programs associated with the welfare state without some recourse to elements beyond the enduring structural arrangements of institutions (Peters et al., 2005: 1280-84).
As Campbell stipulates, the role of ideas within the historical institutionalist school of thought is presented in a somewhat minimalist light with its role being limited to the creation of new policy tools, government agencies and other institutions which limit policy options subsequently (1998: 380). Furthermore, the existence of normative constraints (such as the prevailing norms and values prevalent in society which dictates policymaking behaviour in the institutional environment) has left little room for a role to exist for policy dynamism through ‘ideas’ and ‘discourse’. This is particularly relevant in respect to the theoretical core of traditional historical institutionalist where ‘institutions’ rather than ‘ideas’ are deemed to be the critical constraints in the process of policymaking (Campbell, 1998: 380).

This insufficiency in conceptualising the process of change is sustained further when critically analysing the theoretical workings of the ‘critical junctures’ where the ideal of change is interpreted within the ‘punctuated equilibrium’ remit of the historical institutionalist school of thought. As such, the assumption of a ‘punctuated equilibrium’ signifies that change can only occur under the guise of a *sharp break* from the trajectory on which the policy is moving or as Krasner succinctly describes as “rapid bursts of institutional change followed by long periods of stasis…” (1994: 242 cited in Peters, 2012: 78). Therefore, due to its failure to encapsulate the influence of ‘ideas’ and the process of ‘incremental change’ this has led to a departure from the historical institutionalist theoretical approach in accounting for change within an institutional setting (Peters et al., 2005: 1288-90; Greener, 2005: 64).

### 3.5.8 Conceptualising the process of ‘gradual change’ within historical institutionalism.

In response to critiques of the ‘punctuated equilibrium’ analogy, Streeck and Thelen (2005 cited in Peters, 2012: 80) amongst other academics in the field of historical institutionalism began to develop several theoretical viewpoints on ‘gradual’ change within institutions. This perspective on institutional change engages with the assumption that while the basic structure of policy would remain the same, some change can occur. However, not all changes can be depicted as ‘functional’ for the actual implementation of policy. Rather, ‘change’ can be introduced as a means of giving the impression of
change in order to maintain the status quo or as an attempt to satisfy political demands for change (Peters, 2012: 80).

Similarly to analysing large-scale change depicted through the ‘punctuated equilibrium’ idealism, the original writings of historical institutionalism have tended to focus on ‘exogenous’ sources of change (Mahoney and Thelen, 2010 cited in Peters, 2012: 81). This is primarily based on the assumption that, within stable institutions, policy change can occur overtime in response to ‘exogenous shocks’ that were sufficient enough to overcome the existing equilibrium.

According to this theoretical derivation, Streeck and Thelen propose four modern postulates for analysing gradual change within an ‘exogenous’ forces framework. The first of these is displacement, which occurs when existing patterns of ‘rules’ within an institution are transformed (2005, cited in Peters, 2012: 81). This also represents a restatement of conventional ideas about organisational and policy change. As such, this form of transformation occurs in institutions on a continuous basis and may cumulate to more significant institutional change. The theoretical difficulty with this interpretation however rests with assessing when change is ‘gradual’ and when ‘significant’ change actually occurs (Peters, 2012: 81).

The second strand of gradual institutional change in this framework is the concept of layering. This form of institutional change occurs in response to the imposing of new rules on top-of or alongside existing ones. This style of institutional reform encompasses ‘partial’ re-negotiation of some elements in the structural framework through the attachment of new elements to existing ones. Thirdly, gradual institutional change may also occur in response to the prevailing rules which may drift (Peters, 2012: 81). According to Mahoney and Thelen (2010: 16 cited in Peters, 2012: 81), this essentially results from a transition in ‘rules’ due to institutional neglect of maintenance and changes within the institutional environment. Finally, there is the concept of conversion in institutional change which refers to the practices of using existing rules and structures in different ways. In essence, this form of change occurs when existing institutions are redirected to new purposes (Sitek, 2010: 575; Peters, 2012: 81).

As Peters argues, these three strands of gradual institutional change taken together facilitate the historical institutionalist perspective as a theoretical school of
thought to contend with transition more effectively than the sole option of ‘radical change’ (2012: 81-82).

In their seminal writings, Thelen and Steinmo (1992: 12-26) have also made a notable attempt to rectify the critical inadequacy of institutionalist analysis in its adaption of a static approach to change which has led historical institutionalism theory down a trajectory of institutional determinism. They do so through their derivation of the concept, ‘institutional dynamism’. Within this contextualisation, scholars address change through not only viewing how institutions come to mediate and filter politics but rather start to demonstrate how the impact of institutions itself is mediated by the broader political environment. Hence, there has been a shift towards understanding how institutions come to be formed and changed. In demonstrating this process, Thelen and Steinmo derive a theoretical framework which encapsulates three strands of institutional change. Firstly, they observe broad changes in the socio-economic or political environment whereby change becomes prevalent in the event of previously latent institutions suddenly become salient that in turn lead to significant implications for policy outcomes. Secondly, institutional transition is also refocused to grasp changes which occur in the socio-economic context or where the political balance of power can produce a situation whereby ‘old’ institutions are put in the service of different ends. This occurs in the event of new actors coming to the fore who pursue their new goals through the medium of existing institutions. Finally, institutional change is also being observed in an ‘exogenous’ sense, where change is observed in a shift occurring with respect to the goals or strategies being pursued within existing institutions – i.e. where changes in outcomes occur through old actors adopting new goals within existing ‘old’ institutions (1992: 16-17).

Thus, for modern historical institutionalist scholars, a theoretical shift occurred in which a notable emphasis is now being placed on how institutions themselves interact with the broader socio-economic context in which they operate. While scholars still accept that institutions themselves may be resistant to change, they now acknowledge that political outcomes can change overtime in a subtle manner as a consequence of shifts in the broader socio-economic and/or political environment. Particularly when
analysing how ideational innovation occurs within the confines of institutional constraints.

3.5.9 Policy paradigms and the practice of social learning.

The source of institutional dynamism is explored through analysing the relationship between emerging policy ideals and the institutional configuration which mediates between such ideas and specific policy outcomes. In this sense, ideas are encompassed in the more general programs that underpin policy initiatives (Schmidt, 2008: 306). Essentially, these programs can be cast as ‘paradigms’ in the sense that they reflect the organising principles that orient public policy (Hall, 1993; Schmidt, 2008). Additionally, they are also frames of reference which enable policy actors to resituate themselves in the world (Jobert, 1989; Muller, 1995; cited in Schmidt, 2008: 306). Furthermore, policy programs also serve as ‘programmatic beliefs’ that function within the space which exists between worldviews and specific policy ideals. As such, the programmatic frameworks act as ‘policy cores’ that provide ‘diagnostics’ and ‘prescriptions’ for action (Sabiter and Jenkins-Smith, 1993 cited in Schmidt, 2008: 306). In addition, these policy frameworks also provide ‘problem definitions’ that set the scope and possible solutions to the problems that policy ideas aim to address (J. Matha, unpublished manuscript cited in Schmidt, 2008: 306). Therefore, programmatic ideas define: the problems to be solved by such policies; the issues which are not considered; the goals to be achieved; the norms, methods and instruments to be applied; and the ideals that frame the more immediate policy ideals which are proposed to solve a specific problem (Schmidt, 2008: 306).

The academic writings of Hugh Heclo and Peter A, Hall on the theoretical concept of policy paradigms and political change symbolises by far the most sustained, consistent and systematic attempt within the institutionalist school of thought to accord a pivotal role for ideas in the determination of institutional outcomes (Hay, 2001: 196). Essentially, the theoretical premise derived by Heclo and Hall respectively, is based on an analogy developed by Thomas Kuhn in his ‘The Structure of Scientific Revolutions (1962). In this seminal work, Kuhn demonstrates that the development of science can be contemplated as a succession of more or less enduring paradigms which are punctuated
by periodic ‘revolutions’ through which the ascendant paradigm is challenged and consequently replaced (cited in Hay, 2001: 196-197)\textsuperscript{28}.

In terms of public policy, historical institutionalists, most notably Hall (1993), have extended the theoretical premise of a paradigmatic analogy established by Kuhn in the scientific field to the policymaking arena. This in turn demonstrates that policymaking occurs within the contextual environment of a ‘policy paradigm’. Essentially, this interpretative schema subsequently becomes internalised by politicians, administrators and policy experts. As such, this theoretical approach comes to define a wide range of legitimate policy techniques, mechanisms and instruments which has the ultimate effect of delimiting the very targets and goals of policy initiatives. Thus, this approach has the ultimate effect of contextualising and legitimising what is feasible, practical and desirable within the political sphere (Hay, 2001: 197). This point is succinctly demonstrated by Hall who states that:

“Policy makers customarily work within a framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing.... [T]his framework is embedded in the very terminology through which policymaking communicate about their work, and it is influential precisely because so much of it is taken for granted and unamenable to scrutiny as a whole” (1993: 279).

Identifying policy paradigms enables political scientists, and in particular public policy analysts, to differentiate between: (a) periods of ‘normal’ policymaking and change in which the paradigm remains largely unchallenged at least within the confines of the policymaking arena; and (b) periods of ‘exceptional’ policymaking (and change) which demonstrates that the very parameters, which previously limited policy options,

\textsuperscript{28} During periodic phases of ‘normal’ science, a single paradigm remains ascendant and unchallenged in the sense that it provides an interpretative framework for the delineating of a legitimate range of problems and non-problems, techniques and criteria for scientific adequacy. As a point of contrast, during phases of ‘exceptional science’, an accumulation of anomalies within the ‘old’ paradigm (in this instance this refers to experimental outcomes which did not conform to the predictions of the existing theories) has the effect of leading some scientist to break away from a particular paradigm and the constraints it imposes. More specifically, these scientists search for alternative approaches that potentially resolve the anomalies of the old paradigm, thereby opening a space for a new periodic phase of normal science under the dominance of a new paradigm which would be internalised by the scientific community (Hay, 2001: 197).
are cast asunder and replaced. This leads to recognition of what is politically possible, feasible and desirable to be reconfigured (Hay, 2001: 197). Therefore, ideational elements are very much implicated in the process of political and social change.

The process in which political and social change occurs was one of the central questions which Hall aimed to address through analysing the attributes that motivated policy actors to enact a particular policy (1993: 275). As such, Hall derives the theoretical concept of ‘policymaking as social learning’ 29. In conceptualising the process of social learning, Sacks stipulates:

“the ‘politics as learning’ approach implies that elements within the state, acting, presumably, in pursuit of the national interest, decide what to do without serious opposition from external actors” (1980: 358).

Hence, the practice of social learning is deemed to be a key principle in contemporary theories of the state and indeed in the art of policymaking. Hall (1993) argues that the prevailing model of social learning is to a significant extent premised on Heclo’s work which has been furthered by other state theorists. Essentially, the concept of social learning embodies three central facets. Firstly, academics within this theoretical field suggest that one of the primary factors affecting policy at present is policy enacted previously (Sacks, 1980: 356). Thus, it is attributed that policy responds less directly to social economic conditions than it does to the consequences of past policy. Furthermore, the interests and ideals that policymakers engage in at any particular moment in time is significantly shaped by prevailing ‘policy legacies’ and/or ‘meaningful reactions to previous policies’ (Hall, 1993: 277).

The second feature of social learning places significance on the key agents pushing forward the learning process, whom are the experts within a given field of public policy. These experts consist of actors who act on behalf of the state or those actors which can act in an advisory capacity from privileged positions at the interface between the state and the intellectual spheres of society. Hence, this model grants

29 This conceptualisation of politics under the guise of social learning owes its origins to the academic works on cybernetics and organisation theory, and psychologically oriented versions which have been applied to the process of foreign policymaking (Hall, 1993: 275)
prominence to officials or experts who specialise in specific fields of public policy whilst downgrading the role of the politician in the practice of social learning (Hall, 1993: 277).

A final feature of social learning is its focus on the capacity of the state to act autonomously from state pressures. This derivation is echoed by Heclo who essentially rejects the notion that external factors such as: socio-economic developments; elections; political parties; and organised interests play a pivotal role in the development of social policy and concludes that “if one were forced to hold the policy process static and choose between an essentially pluralistic or elitist interpretation, then our tentative conclusions... would suggest the greater interpretive power of the latter” (1974: 318 cited in Hall, 1993: 278).

In providing a more coherent definition of social learning, the term ‘learning’ denotes a process whereby individuals assimilate new information, which includes past experiences and their application to subsequent actions. This process represents an attempt to adjust the goals or techniques of a particular policy in response to past experience and new information. Additionally, the learning practice may take different forms, depending on the variety of changes in public policy which may be involved. However, the concept of social learning can be disaggregated into specific parts. As Hall points out, the policymaking process within the remit of social learning involves three central variables: (a) the overarching goals that guide policy in a particular field; (b) the techniques or policy instruments utilised to achieve those goals; and (c) the specific settings of these instruments for enacting public policy (1993: 278).

Hall (1993: 278) demonstrates this policy transition process succinctly through analysing the macroeconomic policymaking initiatives which took place in Britain during the 1970-89 period. As such, the radical shift from Keynesian\(^{31}\) to Monetarist\(^{30}\)

\(^{30}\)For example, if the goal of a particular policy is to ease the financial problems of the elderly, the instrument selected might be an old age pension, and its setting would be the level at which benefits were set. This represents a simple change in the level of benefits rather than a potentially more radical transformation in the basic instrument of policy or its overarching goals (Hall, 1993: 278).

\(^{31}\)For most of this period, British Macroeconomic policymaking was based on the principle ideals associated with John Maynard Keynes. Once adapted to the British financial system, Keynesian ideas were institutionalised into the day-to-day practices of the British treasury which in turn formalised the ‘neoclassical syntheses’ within the economics school of thought. The ‘neoclassical syntheses’ specified
mode of macroeconomic regulation during this period encompassed change in all three components of policy: the instrument settings; the instruments themselves; and the hierarchy of goals behind the particular public policy (Hall, 1993: 279). While it is evident that such wholesale changes in policy occur relatively rarely, when they do occur as a consequence of past experience, this process can be described as a third order change (Hall, 1993: 279).

Within this process of social learning and policy paradigm change, it is evident that ‘ideas’ prove to be a central premise in the practice of policy initiation. This point is echoed by Anderson who observes that “the deliberation of public policy takes place within the realm of discourse … policy are made within some system of ideas and standards which is comprehensible and plausible to actors involved (1978: 23 cited in Hall, 1993: 279). In addition, policymakers customarily operate within a framework of ideas and standards that specifies not only the goals of policy and the types of instruments which can be utilised to achieve them, but also the very nature of the problems that they aim to be addressing. Therefore, it is within this interpretation that Hall derived the conceptualisation of a ‘policy framework’ in policymaking (Hall, 1993: 279).

In contextualising further the concept of policy paradigms and change in public policy implementation within Hall’s theoretical construct of ‘first’, ‘second’ and ‘third’ order change; it is prevalent that first and second order changes can be categorically defined as periods of ‘normal policymaking’. This reflects a process in which an adjustment can occur in the policymaking field without altering or challenging the general terms of a given policy paradigm. However, in contrast to the ‘first’ and ‘second’ order of change, the third order of change encompasses a different process, as it enshrines a ‘radical’ change in the overall terms of the policy discourse which consequentially results in a ‘paradigm shift’ (Hall, 1993: 279).

Hence, whilst the first and second orders of change are reflective of preserving the broad continuities associated in the platforms of policymaking; the third order

that the world in the economic context was like, how it was to be observed, which goals were attainable through policy and what instruments should be utilised to achieve them. In essence, this policy paradigm became the foundational principles through which policymakers viewed the economy as well as their role within it (Hall, 1993: 279).
change by contrast is distinctive in that it represents a process of ‘periodic discontinuity’ in public policy. However, the occurrence of first and second ordered change does not systematically lead to third ordered change. Rather, a central characteristic of first order change is that it enshrines features of ‘incrementalism’ in the public policymaking arena through satisficing and routinized decision making. While the second order change in contrast involves the development of new policy instruments which may move one step beyond in the direction of strategic action. The third order of change is associated with the radical change of a policy paradigm and inevitably the policy discourse (Hall, 1993: 279-80).

As such, the transition and progression from one paradigm to another, which features third order changes, involve the accruing of anomalies, experimentation with new forms of policy and policy failures which precipitate in a shift in the locus of authority over policy and initiates a wider contestation between competing paradigms. Therefore, the success of a new policy paradigm relies pivotally on the securing of positions of authority over policymaking which would enable the swift rearrangement of the organisation and standard operating procedures of the policy process. This in turn would institutionalise the ‘new’ paradigm (Hall, 1993: 280-81).

Whilst Hall (1993) acknowledges that a national political discourse sets significant normative limits on policy-making options he fails to conceptualise how these structures have the capacity to provide policy actors in policy debates with a conceptual repertoire for actively framing these options. Therefore, it can be derived that the process of social learning does not capture the constant struggle which exists between ideological models (e.g. neo-liberalism) and policy understandings that make political actors draw different lessons from previously enacted policies (Campbell, 1998: 381).

Despite the disparity between the theoretical variants in this context, scholars of historical institutionalist persuasion have little difficulty with the proponents of discursive institutionalism. This is rooted in the premise that discursive institutionalism adds dynamism to the historical processes of ideational change, through focusing on who talks to whom, where and when. In a similar vein, discursive institutionalism also contributes to the theoretical analogies of historical institutionalism in that it describes
the formal institutional contexts which indelibly shape interactive patterns of discourse (Schmidt, 2010: 16).

3.5.10 Institutional change: Paradigm shifts and the conception of a ‘punctuated evolution’.

For Hay, as a constructivist theorist and ally to discursive institutionalist reasoning, emphasis is placed on using ideas to understand ‘change’ after the formation of the institution, which contrasts to historical institutionalist scholars who are more concerned with ideas at the formative moment (Hay, 2006 cited in Peters, 2012: 75). This point of distinction very much goes to the core of discursive/constructivist institutionalism’s theoretical reasoning in that their study of institutions reflect the indeterminate nature of information and knowledge. In turn, this stipulates that due to social facts, as products of social understandings, being frequently renegotiated institutions then cannot be defined as stable patterns of action and stable rules. Rather they should be interpreted as being more transient and less permanent (Hay, 2006 cited in Peters, 2012: 113).

In Hay’s conceptualisation of the policy learning process over time, emphasis is placed on how specific events are slotted and the conditions through which paradigms are consolidated, challenged or replaced. In this context, the process of institutional and ideational change is considered in terms of the dynamic relationship which exists between the institutional context and institutional conduct. The role of policymaker in this sense is understood to be both strategic and selective in their operational practice. In the formulating of policy, state managers are considered to be influenced by: (a) the cognitive frames within which policy makers operate, that are likely to be privilege certain time-horizons over others in the formulation of policy; (b) perceptions of

32 They have the function of formulating policy within a framework which is ‘strategically reflexive’ and favour certain strategies over others as means of realising them (Jessop, 1990: 9-10 cited in Hay, 2001: 199). In essence, this typical context has the consequence of restricting the range of hypothetical options available to policy actors over particular ‘time horizon’. Accordingly, the knowledge on which they must establish their strategic calculations is most probable to be ill-defined and incomplete. Furthermore, the environment in which they inhabit is selective of the strategies they might deploy in a variety ways, which in turn reflects the institutional capacity of state structures, the resources available to policymakers, the power and influence of interest and pressure groups, the spirit of public opinion and the strength of the domestic economy. Therefore, the nature of assessment by these policy actors rests on what they view as the strategic options available to them is likely to be constrained profusely by perceptions of what they view as feasible, possible and desirable (Hay, 2001: 199).
institutional resources and policymaking capabilities; and (c) the learning they derive from other context through processes of policy transfers and assessments of previous policy successes and failures (Hay, 2001: 198-99).

The process of policy evolution then is characterised by successive stages or recapitulations of strategic learning in the parameters of an evolving paradigm. Within this framework, policy strategists tend to assess the consequences, both intended and unintended of prior policy initiatives in an attempt to contemplate more succinctly the practice of policy implementation. Furthermore, policy strategists also aim to test, in an accurate manner, societal responses to policy initiatives in the hope that they may learn how to design future policies which are more likely to realise policy objectives. However, such exercises in strategic learning cannot guarantee future policy successes, as the context through which policy is formulated is not a static one. As such, this is primarily due to public policy being in a constant process of evolution and transformation. However, not all aspects of the process of change in public policy are attributable to the control of policymakers. Hence, despite the various assumptions derived by scholars on policy evolution, strategic learning is rarely cumulative (Hay, 2001: 199-200).

It is also evident that the exercise of strategic learning, which occurs within a pervasive policy paradigm, tends to be assessed from the viewpoint of policy failures. The reason such policy failures occur is due to parochial factors such as inappropriate choices regarding the settings of policy instruments, rather than with the obsolescence of the policy paradigm itself. Therefore, paradigmatic shifts such as these tend not to occur in response to social or strategic learning on the part of experts, policymakers, bureaucrats or civil servants generally. On the contrary, paradigmatic shifts are in general attributable to, at least within liberal capitalist democracies, the emergence of highly politicised and public debates about the desirability and feasibility of contending political goals (Hay, 2001: 200).

Hence, significant shifts in policy paradigms and the emergence of political contestation derive from moments of widely perceived institutional and state crisis. In this regard, the conception of policy change and institutional change which emerges is not one of “punctuated equilibrium” but one of “punctuated evolution”. This contends
that public policy evolves through the iterative unfolding and adaption of a paradigm to altering circumstances, punctuated by crisis and paradigmatic shifts in public policy (Hay, 2001: 200).

### 3.5.11 Conceptualising ‘change’ and ‘the role of ideas’ within the sociological institutionalist school of thought.

The school of sociological institutionalism, out of the three existing neo-institutionalisms, is perhaps the most closely aligned to the components of discursive institutionalism theory. As such, sociological institutionalism theorists already account for ideas through articulating within its theoretical model a role for ideational processes. Essentially, this comes to the fore when, in an environmental context, institutions come to represent the norms, cognitive frames, scripts and meanings systems which have the effect of guiding human action in accordance with a ‘logic of appropriateness’ (Schmidt, 2010: 14; March and Olsen, 1989; Di Maggio and Powell, 1991). Therefore, as Schmidt outlines with reference to the sociological institutionalist tradition, one cannot ‘talk about a turn to ideas’ due to the fact that ideas have always formed a cornerstone within this school of thought – through its analytical study of norms, frames and meanings systems. (2010: 14).

Highlighting what distinguishes the sociological institutionalist perspective with that of discursive institutionalism then, has proven at times to be ambiguous. Distinctions in this sense are only said to be found when observing a scholars approach and treatment of ideas – such as whether they view ideas as being more culturally determined, static ideational structures and institutions (e.g. macro patterns consistent of ‘actions without agents’) (Hall and Taylor, 1996) or whether they take a more dynamic approach to the study of ideas (Schmidt, 2010: 13). Therefore, the distinguishing characteristics between these two theoretical schools of thought primarily relate to how they engage with the components of cultural framing, ideas and discourse.

In the context of institutional change, scholars in the sociological institutionalist tradition have developed the concept of ‘sedimentation’ (Peters, 2012: 134). This theoretical construct is founded on the premise that human life and current practices are built on the past. Hence, the concept of sedimentation reflects the historical and
cumulative nature of institutions. In terms of institutional transformation, this concept asserts that an institution retains much of its past history. As such, change is interpreted when an institution moving forward redefines itself while actively reflecting on its past. Therefore, institutional change in this sense involves developing new understandings and symbols that are not far removed from those that were in place before. Whilst this theorisation is reflective of ‘incremental’ change, it is nonetheless perceived as being more plausible than a more absolutist position which would depict the replacing of norms and values that make up an institution (Peters, 2012: 134-35).

By comparison, the literature on discursive institutionalism aims to be more dynamic and by extension more competent at explaining the process of institutional change and continuity in the policymaking arena. As such, it can be highlighted that a central point of distinction between the fourth ‘new’ institutionalism and the existing institutionalisms, rational-choice, historical and sociological institutionalism, relates to the portrayal of institutions as being structures external to the agents that constitute rules about acting in the world that serve mainly as constraints –whether that be through the historical paths that shape action or the cultural norms which frame action (Schmidt, 2010: 14).

This is in stark contrast to the discursive institutionalist perspective whereby institutions are perceived to be internal to sentient agents, serving both as structures (in the process of thinking and acting) that constrain action and as constructs (in the process of thinking and acting) in which actors created and changed. Hence, the internal capacity to create and maintain institutions derives from a policy actors ‘background ideational abilities’ (Schmidt, 2010: 14). The concept of ‘background abilities’ is defined as a generic term that encompasses ‘human capacities’, ‘dispositions’, and ‘know-how’ in respect to how policy actors relate to how the world works and how to cope with it (Searle, 1995 cited in Schmidt, 2010: 14). As such, a background ideational ability has the effect of underpinning a policy actor’s ability to make sense in a given meaning context. Therefore, discursive institutionalism eradicates “the impression that actors are institutional dopes blindly following the institutionalised scripts and cues around them” (Campbell, 1998: 382).
3.5.12 Conceptualising policy change: A Historical, Sociological and Discursive institutionalist approach

From the outset, it is prevalent that plotting change through ideas and discourse analysis has to date been underdeveloped. Therefore, it rests with historical institutionalists such as Hall (1993) to account for ideational change through paradigm shifts (as discussed above). However, this approach is not regarded as conclusive due to it failing to specify closely enough the process of ideational change. Most notably: how old ideas fail and new ideas come to the fore; reasons for the occurrence of ideational change; why certain ideas are taken up rather than others; and the timing of ideational change. Moreover, the precept of a policy paradigm with its emphasis on ‘abrupt’ shifts proves to be further inconclusive as it does not account for both evolutionary and revolutionary change in the public policy field (Schmidt, 2010: 14; Béland, 2005: 4-5).

From this realisation, scholars in the discursive institutionalism have sought to build on the existing theoretical construct of ideational change through demonstrating how different elements may be added to ideas, which facilitate change incrementally in times of stability and not just at ‘critical junctures during paradigm shifts’. Thus, the discursive institutionalist perspective builds on existing theoretical foundations through introducing an ‘interactive side of discourse’. By implication, particular attention is placed on how ideas are generated among policy actors and communicated to the public by those in the policy sphere. Therefore, discursive institutionalism deems to offer a less-rationalistic conception of policy change and continuity through providing a more concise analytical framework which focuses exclusively on the ‘ideas’ and ‘discourse’ that informed the policy trajectory (Schmidt, 2008: 313-17).

3.5.13 Discursive Institutionalism: A way forward in understanding the dynamics of policy continuity and change.

The significance of the discursive institutionalist theoretical framework, is that it alludes to a policy actors ability to think outside of the institutions in which they continue to act, to talk about such institutions in a critical way, to communicate and deliberate about them, to persuade themselves as well as others to change their opinions on the
institutions within which the operate, and finally to take action to change them (Schmidt, 2010: 16). This form of action taken may be represented through the building of ‘discursive coalitions’ for reform in opposition to entrenched interests in the coordinative policy sphere or through informing and orienting the citizenry in the communicative political sphere. As such, discursive institutionalism provides a modernised slant within the arena of public administration in that it depicts how the delivery of policy ideals, through a persuasive discourse, facilitates political actors in the winning of elections which in turn gives policy actors a mandate to implement their ideas. In Table 3.1 below, it is surmised how each of the institutionalist perspectives: historical; sociological; and discursive institutionalism compare and contrast in a theoretical context.

33 This reflects a process known in discursive institutionalism theory as, ‘foreground discursive abilities’ (Schmidt, 2010).
Table 3.1 Comparative outline of the theoretical schools of thought in institutionalism: Historical, Sociological and Discursive Institutionalism (adapted from Schmidt, 2010: 5).

<table>
<thead>
<tr>
<th></th>
<th>Historical Institutionalism</th>
<th>Sociological Institutionalism</th>
<th>Discursive Institutionalism</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Object of explanation</strong></td>
<td>Structures and practices</td>
<td>Norms and culture of social agents</td>
<td>Ideas and discourse of sentient agents</td>
</tr>
<tr>
<td><strong>Logic of explanation</strong></td>
<td>Path-dependency</td>
<td>Appropriateness</td>
<td>Communication</td>
</tr>
<tr>
<td><strong>Definition of institutions</strong></td>
<td>Macro-historical structures and regularities</td>
<td>Cultural norms and frames</td>
<td>Meaning structures and constructs</td>
</tr>
<tr>
<td><strong>Approach to change</strong></td>
<td>Static – continuity through path dependency interrupted by critical junctures</td>
<td>Static – continuity through cultural norms and rules</td>
<td>Dynamic – change (and continuity) through ideas and discursive interaction</td>
</tr>
<tr>
<td><strong>Explanation of change</strong></td>
<td>Exogenous shock</td>
<td>Exogenous shock</td>
<td>Endogenous process through background ideational and foreground discursive abilities</td>
</tr>
<tr>
<td><strong>Recent innovations to explain change</strong></td>
<td>Endogenous description of incremental change through layering, drift conversion</td>
<td>Endogenous construction (merge with Discursive Institutionalism)</td>
<td>Endogenous construction through reframing, recasting collective memories and narratives through epistemic communities, advocacy coalition, communicative action, deliberative democracy</td>
</tr>
</tbody>
</table>

3.6 Conclusion
This research is interested in contemplating how institutionalism, in particular historical, sociological and discursive institutionalism, can facilitate an understanding of how modern conceptions of ‘equality’ and ‘efficiency’ came to be embedded in the Irish policymaking field. In section one, a conceptual definition of institutionalism within the ‘new’ institutionalist perspective was derived which placed significant emphasis on how
policy outcomes come to be shaped by prevailing institutional structures and the ‘norms’ and ‘rules’ that constrain human behaviour within an institutional environment.

The historical institutionalist perspective provides insights into how both formal organisations and the informal ‘rules’ and ‘procedures’ structure the conduct of internal participants of an institution. Furthermore, it explored how the institutional persistence of policy trajectories is sustained through ‘path-dependent’ analysis and ‘critical junctures’. In the context of path-dependent analysis, it was determined how patterned policy trajectories occur when policies come to be ‘locked-in’ at formative moments of an institution’s existence. As such, it was depicted that the political sphere is highly susceptible to the self-reinforcing pattern enshrined in path-dependent analysis. As such, this is primarily due to the institutional dense environment having the effect of constraining a policy actor’s behaviour onto particular path-dependent trajectories that are difficult to reverse in the long-run. In addition, the concept of institutional persistence was explored further through the critical juncture theoretical construct, which dictates that once a policy option is chosen it becomes progressively difficult to return to the initial point. However, ‘exogenous’ or ‘radical change’ becomes possible given the ready-available policy alternatives to choose from.

The sociological institutionalist perspective provides significant insights into the ‘internal’ institutional structures in terms of how the cultural norms – normative and cognitive; formal and informal – constrain human behaviour in the initiation of policy. Furthermore, this section also explored through the concept of ‘institutional isomorphism’ how the external environment, society in general and its contained cultural norms, impact on the ‘internal institutional’ environment and in turn policy outcomes. In a similar fashion to historical institutionalism, the sociological institutionalist tradition is also primarily interested in the process of institutional stability and persistence. This came to be reflected in the ideals of ‘cultural persistence’ and the ‘institutionalisation’ of policy ideals.
In the final section, the ‘fourth’ new institutionalist perspective, discursive institutionalism, was examined. As such, it elevates our understanding of the policymaking field through its innate focus on the role of ‘ideas’, ‘discourse’ and the interactive processes associated with coordinative and communicative discourse in shaping public policy. By contrast to the ‘exogenous’ conceptions of institutional change associated with the historical and sociological institutionalists traditions, discursive institutionalism provides an ‘endogenous’ account of change through the dynamism it applies to analysing the interactive forces of discourse and ideas within an institutional environment. While historical institutionalist have attempted to rectify its theoretical framework on change through accounting for ‘gradual institutional change’ and ‘policy paradigm shifts in the process of social learning’, the discursive institutionalist perspective elevates our understanding further through its dynamic conception of change and its focus on the interaction of actors within a communicative and coordinative discourse.

In the following chapter, the critical junctures which shaped health care reform in Ireland will be analysed.
Chapter Four

An examination of the ‘Critical Junctures’ which have shaped the evolution of the Irish Health Care System in the context of ‘equality’ and ‘efficiency’ principles.

4.1 Introduction

As stated previously (in chapter 3, section 3.3.3), the theoretical construct of the critical juncture is a pivotal building block within the historical institutionalist school of thought. In this context, the primary focus is on analysing those central moments in the history of social provision where the particular decisions taken produced a policy trajectory which inevitably shaped the character and scope of social provision in an evolutionary sense.

In an historical context, this chapter reviews critical moments in the evolution of Irish health care provision which have had an indelible impact on the ethos and method of service delivery in contemporary times. The critical junctures, surmised in in Table 4.1, highlight instances where political decisions led to the creation of institutional constraints on the social policy trajectory that ultimately proved to be difficult to alter once established.\(^\text{34}\)

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\(^{34}\)It is important to note that in subsequent chapters, the substance of the latter critical junctures reviewed shall be discussed in much further detail.
4.2 Critical Juncture One: The Irish Poor Laws System.

In retrospect, the Poor Laws era proved to be an imperative cornerstone in the foundation of social legislation in both the Irish and British context during the course of the nineteenth and twentieth centuries. The significance of this early measure in social legislation rests on the premise that the prevailing cultural, economic and social philosophical ideals exercised by political actors during this period established an enduring institutional legacy that was to have a profound impact on the evolution of social policy development. This is particularly pertinent when tracing the development of policy constructs which evolved and continue to characterise the contemporary landscape of health care provision in Ireland. As such, it is attributable that the policy concepts of ‘eligibility’ and ‘means-testing’ criterions, which determine access to public health care provision, in tandem with the ideal of ‘individual responsibility’, enshrined in the existence of private health care provision, came to be institutionalised during the Poor Laws era.
4.2.1 Poor Laws: *founding ideas and principles.*

In the context of tracing the evolution of the modern welfare state, the Poor Laws, albeit minimalist by contemporary standards, represented a foundational cornerstone to the future development of social provision. As Ireland was still under British Rule during this period and subject to the laws and policies devolved from Westminster, the central ideals, both economic and social, that stemmed from the prevailing discourse in British society impacted greatly on the scope of social provision in the Irish context (Gray, 2009). While state intervention in matters of welfare and social provision was generally on the increase from the nineteenth century onwards, it was to a significant extent constrained by what McPherson and Midgley (1987: 9 cited in Cousins, 2005: 7) describe as;

“…the nature of colonial administration gave emerging welfare institutions distinctive features which heavily influenced policy making. Administrations were highly bureaucratic and extremely centralised – designed for control, maintenance of order and downward transmission of policies formulated elsewhere.”

Hence, when conceptualising the significance of the Poor Laws in the evolution of Irish social provision, emphasis must be placed on the prevailing socio-economic ideals in the British context, which significantly influenced the scope and evolution of the Irish Poor Laws during this period.

4.2.2 Poor Laws Foundations: examination of the prevailing economic orthodoxies and conceptions of the social order.

During the 19th and 20th Centuries, the predominant philosophical orthodoxy which dominated the economic and social realms was underpinned by *classical liberalism* – also referred to as *laissez-faire* capitalism. The ideologue of classical liberalism emerged during the 18th century in Britain and proclaimed a demand for individual freedom against aristocratic trade monopolies, patronage and the corrupt use of state power. In progressing to the 19th century, classical liberalism had assumed a double status in the sense that it both proclaimed itself to be a *description* of the way society worked and as a model depicting the manner in which society *should* work. Furthermore, it also
prescribed a society which was to be based on the classical liberalism principles of the: ‘freedom of individuals’; ‘freedom of the market’; and the ‘minimal or nightwatchman state’ (Clarke et al., 1987: 25) As such, the primary role of the state was restricted to protecting the environment or conditions in which individuals could pursue their own interests. As Clarke et al. (1987: 25) states;

“...the state was necessary first, to provide national security through its military forces, second, to preserve the rights of individuals to enjoy the benefits of their efforts – the rights of private property, and third, to regulate the exchanges between individuals so as to prevent corrupt dealing – the rights and duties of contract.”

Therefore, the societal realm of classical liberalism – in tandem with the economic orthodoxy of laissez-faire capitalism – was to ensure that individuals could experience the greatest possible freedom from state interference.

In terms of origin, the idealisms which informed the laissez-faire economic model and societal order can be traced back to the industrial revolution. The arrival of the industrial revolution signified a process of change occurring in respect to the prevailing economic ideals in existence. This in particular came to be realised through the development of ‘industrial capitalism’ which came to be legitimated by the establishment of the ‘political economy’ by a group of economist that were known collectively as ‘classical economists’ (Fraser, 1984: 99). Hence, the 19th came to be dominated by the principles and doctrines associated with laissez-faire capitalism both in terms of the economic and social respective realms (Taylor, 1972: 13).

The classical liberalism tradition during this period sought to promote and explain the role of ‘capital’ and ‘consumption’ which formed a central core of the laissez-faire synthesis. Consequentially, this had the effect of assuaging the nature of human society to be closely related and interlocked to the economic role performed. This came to be reflected in the rise of economic theorisations stemming from Adam Smith, the original theorist of the school of political economy and the author of the influential book in 1776 which outlined his laissez-faire vision; Wealth of Nations (Fraser, 1984: 100).
According to Smith, the cornerstone of his economic theory rested on the premise that consumption was the sole end and purpose of production which contends that the consumer or the citizen would be best served through market forces operating freely. In addition, Smith argued that economic achievement would only occur through enabling individuals to pursue their own ‘self-interest’. This asserts that the general welfare of the people would be best served by the collective pursuit of individual welfare since society itself depicts the sum of individuals in it. In this sense, Smith proclaimed that by pursuing one’s own self-interest, individual persons are ‘led by an invisible hand to promote an end which was not part of his intention’. Essentially, a societal vision is outlined whereby individuals can fulfil their full potential unrestricted by state regulations that would otherwise act as an infringement to his/her liberty. Furthermore, the structure of this society was to symbolise: individuals as entrepreneurs freely investing their capital; bringing together the factors of production; making the decisions; taking the risks and more significantly taking his/her profits (cited in Fraser, 1984: 100).

In terms of state intervention, Smith envisaged a ‘positive’ role for the state in the provision of ‘public services’ which no individual alone could foreseeably provide. This derivation was formulated by Smith’s belief in the fundamental importance of the natural order which in turn enabled him to reconcile the ideal of individual freedom with the pursuit of the general good (Taylor, 1972: 19). However, this conception of state intervention was limited as Smith held a “strong presumption against government activity beyond its fundamental duties of protection against its foreign foes and maintenance of justice.” (Smith, 1776 cited in Taylor, 1972: 19). Therefore, this vision of state intervention within the discourse of laissez-faire capitalism was constrained to maintaining the economic environment and facilitating the exercise of individual freedom.

4.2.3 Assessing the societal discourse in Great Britain during the Poor Laws era: self-help, survival and charity.

When developing a coherent understanding of the significance of the Poor Law period, both in terms of welfare state formation and in the evolution of social provision in
Ireland, it is imperative to conceptualise this early piece of social legislation in the context of the societal, political and economic climate in which it was derived. As McCord (1976: 87) argues, “[f]ailure to place the study of the nineteenth century poor law in its own proper setting has often been responsible for serious historical misunderstanding.”

In terms of the organisation of social provision during this period, Clarke et al., argue that the societal ethos of the laissez-faire ideology advocated three central means in which the welfare of the people could be preserved, which were namely: ‘self-help and the support of family networks’; ‘charity’; and as a last resort the ‘poor relief provided by the state through the Poor Laws (1987: 25). Therefore, the prevailing discourse espoused under the laissez-faire model was one in which support from agencies of either central or local government was the least sought and usually a last resort for individuals. This was primarily due to the prevailing cultural norms and values during this period dictating that it was the duty of the ‘individual’ and not the ‘state’ to protect and improve their own interests. Furthermore, it was also presumed that through engaging in behavioural traits of ‘ thriftiness’ and ‘industrialness’, individuals would be in a better position to protect their own welfare interests. Additionally, the laissez-faire ideologue instilled a vision of social provision in which individuals would utilise the ‘natural’ and social networks of the family, friends and mutual assistance during times of distress (Clarke et al., 1987: 25). As Thane argues, during the nineteenth century, the social networks of the family and friends were almost certainly the first resort in the event of ‘self-help’ measures failing (1996: 19)\textsuperscript{35}.

However, the injustice of the laissez-faire model for society and the economy was most prevalent when considering the circumstances of individuals where the extended family and community networks were too poor to assist or not available due to death or emigration (Thane, 1996: 19). Despite this, the ethos of social provision under the laissez-faire idealisms consistently favoured the efforts of the working classes to

\textsuperscript{35} In spite of this, its significance as a survival strategy of the poor is largely underestimated by historians due to the lack of evidence left behind, unlike the poor relief provided by the state which was recorded because of its official status. Furthermore, it was evident that in the event of work becoming scarce, it was often the extended family which might give support, most often in the form of taking some of the children and providing food and clothing until the crisis was over (Thane, 1996: 19).
organise themselves into mutual support networks in obtaining social security and welfare provision (Clarke et al., 1987: 25-26). In this context, the establishment of ‘Friendly Societies’ were, as Fraser argues, a prime example of working class self-help during the *laissez-faire* period which reflected an ameliorative rather than revolutionary social philosophy. As such, the mutual insurance schemes provided through the Friendly Societies symbolised a collective effort by individuals in trying to finance and secure their own protection from the vagaries of the industrialised system whilst simultaneously maintaining the *laissez-faire* virtues of *thrift* and *self-help* (Fraser, 1984: 108).

**4.2.4 Charity and the concept of ‘eligibility’ as a determinant to receiving social provision.**

The central premise of the Friendly Societies was based upon the provision of mutual assistance when individual self-help was deemed impossible. In the context of membership and accessibility, only individuals from a secure and respectable stratum of the male working class, who earned enough and regularly enough to contribute were welcomed (Thane, 1996: 28). This illustrates further that the concept of ‘eligibility’ formed a significant role in determining accessibility to relief during this period. As Clarke *et al* argue, the assessment of moral character in terms of whether the applicant demonstrated desirable habits of thrift, sobriety, industriousness and decency in character became a central determinant in both the accessibility and distribution elements of charity (1987: 26).

This was particularly prevalent regarding the stringent guidelines that were established by the Charity Organisation Society (COS) which emphasised that charity should only be granted to the ‘deserving’ poor who were victims of circumstances outside their remit of control and whose moral character infers that they will utilise charity as a means of restoring themselves to a state of self-help (Clarke *et al*., 1987: 26). In this context, when sources of provision from mutual insurance organisations such as the Friendly Societies, the family and local community networks were exhausted, charity was regarded as the next option (Thane, 1996: 20). However, the charitable relief envisaged was consistent with the *laissez-faire* ethos in the sense that it was organised...
according to the principle of restoring self-help and enabling individuals to take charge of their situation once again (Clare et al, 1987: 26)\textsuperscript{36}.

4.2.5 The Poor Laws: transition from the Elizabethan ‘Old’ Poor Law (Poor Relief Act, 1601) to the ‘New’ Poor Law (Poor Law Amendment Act, 1834).

In the event of all other means failing, the state provided a minimalist form of social provision through the institution of the Poor Laws legislation (Clarke et al., 1987: 26). There are two principled pieces of Poor Law legislation in this context: the Elizabethan Poor Law Act, 1601 (‘Old’ Poor Law introduced in England and Wales) and the New Poor Law Act, 1834 (introduced in Ireland through Poor Relief (Ireland) Act, 1838).

Within the wider European context, the Elizabethan ‘Old’ Poor Laws system was the most generous during the late eighteenth and early nineteenth centuries. Prior to the 1834 legislation, England held an unusual position in that it was the only country that provided a statutory poor relief system financed by taxation (Kidd, 1999: 10-13). Additionally, Solar argues the English relief system was unique in that it reflected uniformity and comprehensiveness in its structure (Solar 1995 cited in Kidd, 1999: 13).

In terms of administrative structure, the financial base of the English system was rooted in the collection of a local property tax and the services of unpaid officials. However, from the 1830’s onwards there was a downward trend in welfare provision which came to be reflected in the reduction in the costs accrued to ratepayers (tax payers at local level) and the social services provided per head of the population (Fraser, 1984)\textsuperscript{37}.

\textsuperscript{36}The criteria utilised for determining the capacity of individuals to become self-supporting was based on a ‘case-work’ approach. This entailed that careful enquiries would be made into the backgrounds of individuals who sought help. If an individual was deemed worthy of such help, they were given relief in the form of cash and the tools necessary to carry on a trade, help in finding a job and also regular visitations and advice until the individual could in effect ‘stand on their own feet’ (Thane, 1996: 22). Therefore, the ideal of charity at this time effectively followed the ethos of the laissez-faire ideology in terms of the ideals of ‘individualism’ and ‘self-help’.

\textsuperscript{37}As Kidd points out, the level of expenditure on welfare provision fell from £6.7 million in 1831 with a population of 14 million to £4.8 million in 1841 with a population of 16 million. In terms of access to relief, it was evident during this period there was a significant decline in receiving welfare from 6.3\% of the population in 1849 to 2.5\% of the population by 1900. The central reasoning for this was due to the emerging intellectual opinion of the time holding the belief that excessive social relief was detrimental to the economy and to the individual’s future well-being (Kidd, 1999: 11).
In terms of its founding principles, the ‘Old’ Poor Laws enshrined a twin purpose which was to assist the impotent (the old, sick and infirm) whilst setting the able-bodied to work. During the seventeenth and eighteenth centuries, the Old Poor Laws came to encompass a concern with establishing a system of relief enforcing discipline and community responsibility for the least well off in society. Thus, on the part of government, it was generally assumed that the poor themselves were entitled to relief should they require it. Despite this notion of entitlement lacking a legalistic interpretation in statutory terms, society in England practiced community responsibility through the recognition that the poor were an integral rather than a marginal element in society. It is interesting to note that the allowance system which stemmed from the Old Poor Laws form of relief proved to be the most generous form of social provision in Europe at this time through its ‘outdoor relief’ policy.\(^{38}\) (Kidd, 1999: 14-19) (Brundage, 2002: 27-29).

The reason for this steady decline was, as Fraser argues, due to aspects such as population growth, increased social mobility, industrialization and economic fluctuations stretching to the limit a Poor Law system which was designed for a pre-industrial feudal society (1984: 35). Therefore, the trajectory leading up to the reform of the Poor Laws in 1834 in England was symptomatic of constructing a restrictive plan aimed at ameliorating the condition of the labouring poor. It was evident in this sense that the perceived shortcomings led to a strong ‘abolitionist’\(^{39}\) case for the elimination of the Poor Laws institution of welfare provision in its entirety. However, from the 1820 onwards the abolitionist theory was gradually eroded and replaced with a compromised

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\(^{38}\) In reflecting this sense of community responsibility Boyer argues that there were six methods utilised by rural parishes at this time in granting relief to able-bodied poor labourers between 1780 and 1834: allowance-in-aid of wages (allowance system); payments to labourers with large families; payments to labourers with large families; payments to seasonally unemployed agri-labourers; the roundsmen system (parish paid the occupiers of property to employ applicants of relief at a wage rate set by the parish.); the labour rate and finally the workhouse system (Boyer, 1990: 10).

\(^{39}\) As Fraser (1984, 38-39) states, prominent abolitionists at the time such as Malthus who argued in his influential Essay on the Principle of Population the Poor Law enhanced the already high rates of the rapidly increasing population. The central premise of Malthus theory was that if left unrestrained by certain checks, the population growth would outstrip the means of subsistence. Similar ideals were also proposed by Ricardo in his Principles of Political Economy where he argued that the increasing level of expenditure on Poor Law relief had the consequential effect of reducing the level of wages. Therefore, according to Ricardo this created a vicious circle whereby individuals were forced into pauperism due to wages being forced down.
solution which aimed to rid the Poor Laws of its defects and stop short of abolition. In this sense, it became increasingly evident that the central motive for the ‘New’ Poor Law reform was not to facilitate social redistribution or social solidarity but rather to reduce the increasing levels of Poor Law expenditure paid by the propertied class through the ‘rates’ system (Fraser, 1984: 37-39).

In stark contrast to the Elizabethan ‘Old’ Poor Law then, the ‘New’ Poor Law Act, 1834 proved to be much narrower and punitive in its approach to applications for relief. Despite the minimalist outlook of the 1834 legislation, it almost by default found itself being responsible for a wide range of services for the sick, infirm and children. The chief institution which represented the Poor Law relief during this time, the ‘workhouse’, later transformed from an institution utilised as a deterrent mechanism by its creators to something closely symbolising the origins of a state hospital system (Kidd, 1999: 8). Hence, the Poor Laws can be depicted as being representative of an institutional cornerstone in establishing the founding principles of what would evolve to become the modern welfare state.

When evaluating the prevailing ideological, socio-economic and cultural context of this period, it is attributable that the principles of laissez-faire capitalism in tandem with the ideals of minimal state intervention and the upholding of individual responsibility was the predominant ethos dictating the minimalist nature of state provision. Furthermore, the philosophical thinking which informed the laissez-faire orthodoxy such as the classical-political economy, utilitarianism and evangelism proved to be crucial in setting the scope of the New Poor Law and in turn setting the values and standards for the ‘liberal state’ during this period (Kidd, 1999: 8).

Pierson in characterising the ‘liberal state’ during this period describes that the primary concern of states operating under the ‘Poor Laws’ legislation was with the maintenance of public order, the punishment of vagrancy and the management of the labour market (2006: 108). Within this paradigm of state responsibility, the advancement in well-being of the poor featured as a lesser concern.
4.2.6 The arrival Poor Laws to Ireland: assessing the foundations of social provision in Ireland.

In chronicling the arrival of the Poor Laws to Ireland and its eventual application, the social and economic idealisms which influenced the passing of the English Poor Laws also impacted in shaping the Irish version of this early measure of welfare provision. This is particularly noteworthy when understanding how the policy concepts ‘deserving’ and ‘undeserving poor’ originated. In retrospect, both concepts formed a crucial institutional element in laying down the foundational parameters of the Irish welfare state. Contextually, this came to be reinforced at this critical juncture through the policy constructs of ‘less eligibility’ and the ‘workhouse test’; both of which acted as an eligibility criterion and determinant of access to social provision (Burke, 1987) (Gray, 2009).

Within the British context, the realisation of the need for a Poor Law for Ireland was deeply intertwined with the ideals of welfare entitlement and social citizenship in a similar essence to the rationale behind the enactment English system. Furthermore, the stimulus behind the enactment of the Irish Poor Laws measure also rested on the premise that poverty was proving to be a characteristic deeply engrained across the Irish landscape. From the viewpoint of overseas observers, it was thought that the root causes of poverty lay in the country’s inherent barbarism and social backwardness. As such, it was highlighted by observers that: the country’s religious or racial difference; Ireland’s political subordination; and the deviant characteristics of its agrarian structures were the dominant precursors. However, by the nineteenth century and prior to the introduction of the Poor Laws, the issue of Irish poverty was becoming increasingly recognised as remediable and as a legacy of misgovernment by the Parliament at Westminster and its Anglo-Irish proxies. Thus, the Poor Laws social infrastructure in Ireland came to be recognised as an enabler in facilitating economic development and the addressing of humanitarian concerns during this period (Gray, 2009: 9-10).

Prior to the introduction of the Poor Relief (Ireland) Act, 1838 there was a clear absence of a ‘national legislative framework’ to establishing a system of state welfare provision in Ireland. This was due to the institutional model of poor relief which existed in England did not apply to Ireland. However, this did not translate that Ireland was
without some of the aspects which characterised the Elizabethan or ‘old’ Poor Law measures of social provision\(^40\) (Gray, 2009: 8-10).

### 4.2.7 The construction of the Irish Poor Laws: Assessing the dominant influences on its enactment.

When evaluating the process which led to the eventual arrival of the Poor Laws to Ireland, two contrasting personalities dominate any understanding of how this foundational form of welfare provision emerged. The first figure to draw up plans for social and economic reforms in the Irish context was Richard Whately, a scholar and Churchman. While the second British emissary to draft a reform programme for Ireland was George Nicholls, a ship’s captain, an overseer of the Poor Laws and ever-willing spokesperson of its establishment (Burke, 1987: 17).

In regards to the former, upon the establishment of the Royal Commission of Inquiry (the Whately Commission) into the conditions of the poor classes in Ireland on 25 September 1833, Whately as the resident Church of Ireland Archbishop of Dublin was appointed as its chairman. From the outset, the establishment of the Irish Commission was viewed as a means through which the government could shelve a difficult problem. Notwithstanding this perception, under Whately’s leadership the Irish Commission outlined its mission which was;

> “endeavouring to prevent the existence of destitution [rather than merely devising a] means for alleviating misery after it had arisen. We shall feel deep pain should we ultimately be compelled to leave any portion of the Peasantry of Ireland in a continuation of distress on the one hand, or a mere offer of charity on the other” (1\(^{st}\) Report of the Irish Commission, cited in Burke, 1987: 19).

\(^{40}\) For instance, from 1817, Mendicity associations were established in Dublin and other provincial centres with the objective of granting indoor day-time employment to the destitute. Public subscriptions for initiatives such as this were sought on the premise that the structured and disciplined charity provided by these institutions would remove beggary from the streets, provide a labour-test to ascertain real need and consequentially lead to a reduction in the total amount of funding provided privately. Therefore, the concept of less-eligibility through the labour-test was not unknown in Ireland prior to the Poor Relief (Ireland) Act, 1838 (Gray, 2009: 13).
As Burke points out, the culmination of the reports stemming from the Commission lived up to this ideal as they demonstrated a motivation to both provide social services for the destitute victims whilst also anticipating a broader plan of reform in the realm of social policy (Burke, 1987: 19).

4.2.8 The enactment of the New Poor Act, 1834: Establishing the parameters for the Irish social reform agenda.

While the Whately Commission was undergoing its research into the level of destitution in Ireland, proposals for reform in social provision were unfolding swiftly in England following the publication in 1834 of the Report of the Commission on the Administration and Operations of the Laws for the Relief Poor. The publication of this report and the pursuant legislation which followed were to have a profound consequence for Poor Laws policy in both Ireland and England. As such, the English Royal Commission in 1832 through the publication of its report dramatically shaped the direction and scope of the New Poor Law Act of 1834 (Burke, 1987: 20). The two most influential members of the English Royal Commission were: Edwin Chadwick, a utilitarian; and Nessau Senior, a leading laissez-faire economist (Fraser, 1984: 42). Both men primarily believed that the Elizabethan Poor Law which was perceived to be: lax in administration; high in cost and proven to be excessively generous in its relief of the poor. Furthermore, it was thought not to be serving the greatest good of the greatest number in nineteenth century England. Therefore, it was affirmed that the Elizabethan Poor Laws measure of social provision should be abolished and replaced by a new Poor Law, or a workhouse system which it came to evolve into (Burke, 1987: 20).

Hence, one of the predominant problems facing Poor Law reformers in the early 1830’s was to assuage how best to provide for the poor without making people too dependent on the state, rather than rely on their own capacities to work and fend for themselves. This formed part of a belief held by the Royal Commissioners that granting relief to the ‘able-bodied’ would effectively pauperise large sections of the population. Thus, it was thought that living off the parish had become more attractive than working. The discourse of public policy during this period then, was one which dictated that those who sought employment could find it. This reflected an individualist philosophy which
contained that if a man was poor it was his own fault because he did not work (Burke, 1987: 20-21).

Within an overarching framework of the welfare state, the findings and recommendations of the report were deeply rooted in the ideal that welfare provision was an unnecessary evil in which through the allowance system it not only demoralised people and depressed wages, it offered an invitation to idleness. Hence, the objective of the Royal Commissioners in the English context was to find a solution which would deter individuals from quitting their status in active employment to join and become members of an eligible class of paupers. This informed the ethos of the report in respect to social provision which ensured by institutional design that the relief provided would be below the standard of living experienced by the industrious labourer (Fraser, 1984: 45). As Brundage states, this was determined through the introduction of the concepts of ‘less-eligibility’ and the ‘workhouse test’ (2002: 66). This policy construct of eligibility was utilised as a means of ensuring that the able-bodied and their families can only access the workhouse through a test of their destitution (Brundage, 2002: 66). More significantly, it also had the effect of ensuring that the laissez faire ideals of individualism and self-help were preserved at the expense of social redistribution.

4.2.9 The Whately Commission: the presentation of its findings and its outright rejection.

As the New Poor Law began to develop at a progressive rate in England, this put increasing pressure on the Whately Commission in Ireland to conclude its findings and present its recommendations to deal with the level of destitution amongst the Irish poor. In the recommendations put forward, the Commission firstly rejected the extension of the English Poor Law to Ireland. On this point of departure from the policy discourse, the Commission argued that there was no point in compelling individuals, through the enforcement of the workhouse test, when for the vast majority of the population no work

\[ \text{41 Within the workhouse, the poor were subjected to a strict discipline, hard work, monotonous diet and separation from family members. As such, the primary objective of the twin concepts of ‘less eligibility’ and the ‘workhouse test’ assured that the practical living conditions within these institutions were so undesirable that the labouring classes would undertake any course of action short of starvation rather than submit to these conditions (Brundage, 2002: 66).} \]
was to be found (Burke, 1987: 29). This was primarily due to: the social backwardness of the country; the inefficiency of the Irish agricultural economy; and clear absence of alternative forms of employment. Additionally, the rural population was excessive for the amount of employment obtainable which caused underdevelopment in the division of labour and low and erratic wages. Therefore, the sheer scale of unemployment and impoverishment in the country and the stark contrast to the conditions in England provided the foundation for the Commissioners to reject the application of the English Poor Law to Ireland. Instead, they outlined in their report an ambitious economic and social development plan which aimed to provide employment and essential social services to the Irish population (Gray, 2009: 118-119).

In terms of social provision, the Commission found that only certain categories of the poor could be safely granted an entitlement to social relief. As such, they outlined a number of key social welfare measures to address the growing impoverishment in Ireland. Firstly, the impotent poor comprising of the “incurable as well as the curable lunatics, …idiots, epileptic persons, cripples, deaf and dumb and blind poor” (Third Report of the Irish Commission, 1833: 43 cited in Gray, 2009: 118) were to be provided relief through the hospitals, infirmaries or convalescent establishments. However, it was believed that the majority of relief should be provided through a plan of voluntary associations funded through charitable donation and where necessary by rates through public levies being placed on the land. In addition, it was envisaged that the Poor Law Commission would act as a regulator of the network of institutions established by voluntary associations. While the Poor Law Commission may make grants in aid out of the rates, the Whately Commission envisaged that it would not take responsibility for the direct provision of services. Therefore, it was thought that once voluntarism in Ireland took hold, reliance on public support would gradually be reduced (Gray, 2009: 119).

In respect to the last category, the able-bodied poor – persons capable of supporting themselves and their families through work but unable to find employment – were to get no state assistance from the rates. Instead the Commission put forward an
advanced plan for its time consisting of state assisted emigration and once the surplus population reduced; employment reproduction initiatives⁴² (Gray, 2009: 120).

From the above recommendations’, there was a clear focus on the prevention of poverty rather than a cure to destitution in Ireland. This proved to be a conceptualisation that the English Poor Law Inquiry never fully contemplated, but one in which the chairman of the Commission, Whately, placed a firm belief in. While the methods of the Whately Commission through state assisted emigration and land improvement appeared from the outset interventionist, the laissez faire idealism was to be realised eventually when the initial state assistance produced a virtuous circle of largely self-financed colonization and agricultural development. Furthermore, Whately also demonstrated an adverse attitude to experiments that focused solely on granting welfare entitlement which were perceived to only serve the squeezing out of investment (Gray, 2009: 128).

4.2.10 Nicholls and the introduction of the Irish Poor Law of 1838.

In terms of highlighting the divergences which existed between Parliament and the Whately Commission regarding social reform during this period, Beckett states the “[p]roposals [were] so completely at variance with government policy and had no chance of being accepted, and were indeed, hardly ever considered” (cited in Burke, 1987: 37). The differences of opinion that existed between government and the Commission was based on the fact that social policy was then, indeed as it is now, deeply influenced by the prevailing social philosophy of the day. As government policy during the nineteenth century was deeply influenced by the doctrines of classical liberalism laissez-faire capitalism, this conflicted significantly to the ideals presented in the Whately Commission’s report which appeared interventionist with respect to social provision. Furthermore, it was perceived that if the ideals and recommendations of the report were to be implemented, greater state intervention was required which would have been intolerable by the advocates of the laissez-faire doctrine (Burke, 1987: 37).

⁴² One such initiative was to occur through the establishment of the ‘Board of Improvement’ which would survey waste lands and improve them by aerial drainage and road building in tandem with enforcement of proper fencing and drainage of private lands through which there would be a generous loan package made available to private landowners. Additionally, it was also envisaged that each district would consist of agricultural schools as a means of developing employment (Gray, 2009: 120).
The Whig government of 1836 was also operating with a slender margin in Parliament which meant that even in the event of the cabinet accepting the findings of the Whately Commission, it is disputable if they would have risked electoral defeat through proposing such a radical plan for Ireland. Hence, it was for this reason that Chadwick’s Poor Law system of ‘deterring pauperism’ was more acceptable to the British cabinet than the ambitious objective of ‘preventing poverty’. However, despite the British cabinet’s inherent disagreement with the recommendations of the Whately Commission, they could not disregard the Commission they established. Therefore, the government decided to send to Ireland another emissary, George Nicholls an appointed Poor Law Commissioner under the English Poor Law system, whose views they knew corroborated with their own, to conduct another enquiry. Prior to the Whately Commission’s publication of its report and findings, Nicholl’s made it known to the British cabinet that the English Poor Law system should be extended to Ireland. (Burke, 1987: 37-38).

In terms of the solutions put forward by Nicholls in his reports, it was acknowledged that the workhouse system was necessary;

‘as a first step, towards effecting an improvement in the character, habits and social conditions of the people. Without such improvement, peace, good order and security cannot exist in Ireland: and without these, it is vain to look for that accumulation of wealth, and influx of capital, which are necessary for developing its resources, agricultural and commercial, and for providing profitable employment for the population’ (2nd Report of George Nicholls, ESQ., to Her Majesty’s Principal Secretary of State for the Home Department on Poor Laws, Ireland, 1837 cited in Burke, 1987: 42).

Furthermore, Nicholls in a similar manner to Chadwick also rejected the ideal of any form outdoor relief provision being granted under the Irish Poor Laws system. However, the form of indoor relief (Irish workhouse institutions) envisaged by Nicholls was estimated by the Whately Commission, if implemented in Ireland, would have to provide accommodation for almost two and a half million people. In spite of this, Nicholls disagreed and in turn calculated that the Irish workhouses would need to...
provide for 80,000 people, of which there would be 100 workhouses capable of meeting the needs of 800 inmates (Burke, 1987: 42-43).

The Poor Laws system envisaged Nicholls came into existence in Ireland through the guise of the Poor Relief (Ireland) Act, 1838. As Burke surmises, the main provisions of the legislative act are as follows;

“…the country was divided into unions and each union had to provide a workhouse for the relief of the destitute poor in the Union, a board of guardians was elected in each union to administer the poor law, and they had to levy a compulsory rate in the union to finance the administration of the poor law (Burke, 1987: 46).

Furthermore, the granting of relief was at the sole discretion of the board of guardians and thus pertained that no poor person, regardless of the level of impoverishment, could be held to have a statutory right to relief. As such, relief was only to be granted in the confines of the workhouse system and preference was to be granted to the aged, the infirm, the defective, children and people resident in the union in which the workhouse was constructed. In respect to the centralised line of authority, the Poor Law Commissioners for England and Wales, which resided in London, held the overall control in implementing the provisions of the Irish act (Burke, 1987: 46-47).

Upon the publication of the two reports on the Irish Poor Law, it was evident that Nicholls was a staunch advocate of the both the laissez-faire and utilitarian doctrines. Through the publication of the reports which influenced the enactment of the Irish Poor Laws in 1838, Nicholls demonstrated a belief in a minimalist form of state intervention in the shape of the workhouse system which he deemed necessary for Ireland. When comparing Nicholls reports and the reports of the Whately Commission, there were two diverging philosophical ideals present on the Poor Laws and indeed conceptions on welfare provision in a general sense. The Whately’s Commission’s conceptualisation was symbolic of encompassing a broad humanitarian ethos through a concern for the individual in need. This contrasted greatly to Nicholls Poor Laws vision which was not concerned with meeting the individual needs of the poor and the destitute but rather with protecting the rest of the community from the pauper; which transgressed that the pauper must be restrained behind the high walls of the workhouse (Burke, 1987: 43-44).
4.2.11 Summary of the key developments during this critical juncture.

- The doctrine of *laissez-faire* capitalism instilled a notion of individual responsibility for personal and familial welfare without excessive state intervention.
- The establishment of the policy constructs of ‘deserving and undeserving poor’ and ‘less-eligibility and the ‘workhouse test’ affirms in a foundational sense that *universal entitlement* was not to form a defining characteristic in accessing public social services.
- The preservation of the voluntary/private associations as the principal providers in the provision of welfare services demonstrated that the State at this foundational stage was not willing to adopt a monopolistic role in the provision of social services.

4.3 Critical Juncture Two – *The establishment of the Irish Dispensary System, 1851.*

The establishment of the Irish Dispensary system, as a critical juncture, proved to be a fundamental cornerstone in developing the infrastructure which formed a central core of the primary health care sector in Ireland. Cassell argues that this institution grew out of the Irish medical charities which appeared during the eighteenth and nineteenth centuries (1997: 1). The Irish medical charities formed as part of a larger movement that witnessed the establishment of hospitals and other institutional facilities throughout the British Isles. In the broadest context, the conceptual term ‘medical charity’ came to encompass a wide-array of institutions which ranged from simple one-room dispensaries to large hospitals and also from all-purpose facilities to those specialising in specific diseases such as the incurables, fever, venereal disease and the insane. However, the vast majority of medical provision in Ireland was delivered through the county infirmaries, the fever hospitals and the dispensaries (Cassell, 1997: 1).

4.3.2 Assessing the dispensary system in its foundation.

The dispensary system evolved in Ireland in the late eighteenth century largely in response to emerging epidemics associated with urban sickness and poverty. These institutions, which were largely voluntary in nature and dependant on charity for
subsistence, differed from the county infirmaries and voluntary hospitals in the sense that they had no wards or in-patient facilities; and professional advice and medicine were provided on an out-patient basis which also included visiting the sick in their homes (Geary, 2004: 54). The distinctiveness of the dispensary system as a tier of health service delivery from that of the services provided by the infirmaries was described by Warburton et al. in their 1818 history of Dublin as “an institution where medicine and advice are given gratis to the poor without any other accommodation” (Vol 2: 736 cited in Geary, 2004: 54).

By the latter half of the eighteenth century, few dispensaries had been established by the members of the gentry as purely private charity initiatives. However, dispensaries were given official recognition by the 1805 Act of Parliament. Through this enactment, Local Government administrators/Grand Juries and the governors of the county infirmaries were empowered to establish dispensaries in areas that were too distant from the infirmaries which in turn prohibited the provision of medical aid to the poor. Initially, the original dispensaries were conceived as outlying auxiliaries with the central purpose of providing deserving poor with free medicines for comparatively remediable ailments (Cassell, 1997: 8).

4.3.3 The Medical Charities (Ireland) Act, 1851 – reforming the dispensary system on a statutory footing.

Following the death and human suffering which was caused by the Great Famine, the Medical Charities (Ireland) Act was introduced in 1851. In parallel with the strains placed on the health of the nation, the famine brought a tidal wave of sickness and disease which threatened to submerge the existing medical infrastructure established under the medical charity system. As Geary points out, between the years of 1845 and 1852, general starvation and opportunistic diseases accounted for more than one million

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43 The Irish Parliament in 1705 passed the Infirmaries Act which permitted the establishment of an infirmary in every county with the exception of Dublin and Waterford (both had already existing facilities in place). The Infirmaries act proved to be a considerable success due to it establishing an initial administrative and funding model through which other aspects of medical charity could be derived (Cassell, 1997: 2-3).
The epidemic afflicted by the famine was intensified further with the emergence of other infectious medical conditions such as diarrhoea, influenza, measles, pneumonia, smallpox and tuberculosis. Additionally, the appearance of Asiatic cholera in 1848-9 exasperated the situation further. Due to the number of existing dispensaries being unevenly distributed throughout the country, this made the system particularly susceptible to strain in times of duress. Hence, the linkage between raising private funding and receiving government subsidies demonstrated that the inefficiencies were primarily associated with the fact that ‘philanthropy’ rather than ‘necessity’ dictated the number and location of dispensaries in pre-famine Ireland (Geary, 2004: 63).

As such, the Medical Charities (Ireland) Act, 1851 represented a significant shift in transforming the nature of poor relief in Ireland than had been acknowledged. Generally, the Dispensary Act brought the dispensary system under the jurisdiction of the Irish Poor Law Commission. However, despite the significance of this legislation and its advancement in respect to the welfare state project, historians have failed to appreciate the effect of the new form of medical relief responsibilities that was bestowed upon the Poor Law authorities or the broader public health powers which were enshrined in the act. As Cassell surmises, the act accomplished three things;

“it turned the beleaguered dispensary system over to the Poor Law Commission; it reorganised that agency by requiring it to have a medical commissioner and medical inspectors; and, by giving the commission the authority to enforce the Nuisances Removal and Diseases Prevention Acts of 1848 and 1849 in periods when the country was threatened by epidemic disease, it transformed the commission into something like a national board of health” (1997: 78).

Therefore, the significance of this law rests on the extensive powers granted to the Irish Poor Law Commission within the domain of medical relief which till this point was unprecedented in Ireland and unparalleled in the rest of the United Kingdom until the establishment of the Local Government Board in 1871 (Cassell, 1997: 78).

The central focal point of this legislative enactment was to reform the dispensary system. Under the remit of this act, the country’s Poor Law unions, which had expanded from the original 130 to 163 during the Great Famine were divided into 723 dispensary districts, with at a minimum one dispensary per every district (Geary, 2004: 210)
(Barrington, 1987: 8). The organisational structure of the dispensary service is summarised in Table 4.2 below;

Table 4.2 Organisation of the dispensary service under the 1851 Medical Charities Act (adapted from Geary, 2004: 210).

<table>
<thead>
<tr>
<th></th>
<th>Poor law unions</th>
<th>Dispensary districts</th>
<th>Dispensaries</th>
<th>Doctors</th>
<th>Apothecaries</th>
<th>Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leinster</td>
<td>40</td>
<td>208</td>
<td>308</td>
<td>230</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Ulster</td>
<td>44</td>
<td>215</td>
<td>260</td>
<td>222</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Connaught</td>
<td>29</td>
<td>95</td>
<td>108</td>
<td>103</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Munster</td>
<td>50</td>
<td>205</td>
<td>284</td>
<td>221</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>163</td>
<td>723</td>
<td>960</td>
<td>776</td>
<td>29</td>
<td>7</td>
</tr>
</tbody>
</table>

4.3.4 The operative practice of the Irish Dispensary System.

According to Barrington, the timing of the decision to introduce the dispensary system occurred almost by chance in that it developed in the midst of new educational advancements emerging in the field of medicine and when entry into the medical profession was becoming increasingly regulated. These changes in turn led to the creation of the ‘general practitioner’, which was essentially a doctor trained in medicine, surgery and midwifery. The regulation of this new grade in medical expertise was bestowed upon the Poor Law Commission, which ensured that all new recruits had recognised certificates in medicine, surgery, many years before they were formally made legal requirements in the domain of medical registration. Following the successful election by the board of guardians, each doctor was subsequently appointed to his dispensary district (Barrington, 1987: 8).

The duties of the dispensary doctor once appointed proved to be very onerous. They were expected to treat a vast array of ailments which were present in the patient population. Additionally, by virtue of the smallpox vaccination and nuisance removal legislation being introduced ensured that a large proportion of the dispensary doctor’s time was consumed in the tracking of such epidemics as they presented themselves (Cox, 2010: 61). As time progressed, physicians continued to accumulate more roles, such as in 1874 they became the medical officers of health (MOH) in their respective districts, a title which entitled them to receive a further salary (Barrington, 1987: 9)
4.3.5 Determinants of access to health care provision: eligibility of entitlement and the dispensary system.

In terms of access to health care provision, under the dispensary system only persons with valid relief tickets were qualified for treatment from the medical officers. There were two types of tickets provided, with both offering different degrees of entitlement. These were the black (E-1) – which entitled holders or his dependents to attend the doctor at the dispensary – and the red (E-2) ticket – also known to doctors as the ‘scarlet runner’ – which entitled holders to be seen to by a doctor in their home (Cox, 2010: 61) (Barrington, 1987: 8).

The responsibility for the distribution of dispensary tickets rested solely with the dispensary committee members or the Poor Law relieving officers and wardens. By contrast to other aspects of the Poor Law welfare regime, patients’ entitlement to the services provided was not precisely defined. Therefore, the individuals who were empowered to issue relief tickets determined a patient’s entitlement to medical relief (Cox, 2010: 61). As Cassell (1996: 5) points out, this resulted in what can be depicted as a liberal interpretation of the phrase ‘poor persons’. Notwithstanding this, the number of patients availing of the dispensary service expanded in the decade following its establishment – rising from 11 per cent of the population in its first year of operation to 13 per cent in the period 1871-72 (Cassell, 1996: 96).

4.3.6 Assessing the concepts of efficiency and equality in service delivery under the dispensary system.

The disadvantages associated with the performance of the dispensary system were primarily and increasingly felt by the medical profession, particularly regarding conditions of work. Following the passing the 1851 act, appointments to the newly established districts were prized in the medical profession (Cox, 2010: 62). While the Medical Registration Act, 1858 established a common medical register of persons qualified to practice medicine and a council to supervise education and medical practice for both Great Britain and Ireland, the organisation of the Irish medical profession differed somewhat to Great Britain’s. In the first instance, the most significant distinction rested on the fact that almost half of the 2,200 registered medical
practitioners in Ireland were employed as dispensary or workhouse medical officers. If calculated in conjunction with the surgeons employed in the infirmaries and the medical practitioners in the lunatic asylums, it was evident that the number of practicing doctors reliant on the state for income was excessively high (Barrington, 1987: 16).

The primary reason for this reliance on the state for income was due to the dispensary posts being perceived as positions offering a secure source of income and an opportunity for new entrants to the profession (Cox, 2010: 62). One of central reasons for this sense of security rested on the fact that with Ireland’s low level of industrial development in most parts of the country, there was little scope for the medical practitioners to engage in private practice (Barrington, 1987: 16; Cox, 2010: 62). However, as Barrington points out, while it appeared that Irish health policy was traversing down a path of a state medical service, private practice still upheld a position in the delivery of medical care in Ireland that would eventually flourish upon the advancement and improvement of the economic environment (1987: 17).

The grievances associated with the establishment of the dispensary system were also felt by the population in receipt of such care. The principle cause of distress for Irish people during this period was securing access to such health care provision. As such, access to health care was predetermined by the distance of travel to a dispensary depot and a narrow conception of ‘eligibility’ of entitlement. Despite Irish transport infrastructure advancing considerably throughout the nineteenth century, the administrative bodies and their respective personnel were becoming increasingly aware of the challenges associated with size issues or the caption area feasibility which the dispensary districts presented. This was particularly pertinent given that patients were only entitled to receive medical relief from the districts within which they resided, rather than the depot nearest to their homes (Cox, 2010: 66).

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44 For instance, in the New Ross Poor Law union, the estimated size of Dysartmoon dispensary district was over 21,416 statute acres (approximately 33.5 square miles) while The Rower district was only 7,062 statute acres (approximately 11 square miles). This undoubtedly led to the decision of absorbing the Rower district back into the Dysartmoon district in 1855. In the context of the west and north-west coast of Ireland, the size and variations was much greater. In the Glenties Poor Law union, Dungloe dispensary district comprised 72,220 statute acres (approximately 112.8 square miles), while Killybegs district was 12,625 statute acres (approximately 19.7 square miles). Some of these districts were consolidated following the decline in the number of dispensaries on 1872 from 723 to 719 (Cox, 2010: 66)
Another issue which would prove to be much more contentious and hold significant resonance in shaping the scope of the contemporary health care system was that of equality of access to medical relief. In this sense, the principle ‘inequality’ in health care delivery under the present guise of the two-tier system of public versus private access to health care provision was borne out of the establishment of the dispensary system. In this regard, it is imperative to conceptualise the operation of the black (E-1) and the red (E-2) relief tickets in operation.

In the event of persons being too ill to appear at a dispensary depot in person, families or friends were obligated to seek and obtain a red ticket (E-2). Subsequently, the MO of the respective district would be presented with the ticket and expected to attend to the patient in their home. There were however a number of concerns relating to the practice in which the dispensary tickets were dispensed. For instance, in 1857 the Poor Law commissioners issued a request to management committees to select a time for the presentation of the tickets at the home of the MO (in some instances before 9am). This enabled the dispensary MO’s to visit the home of the patient on the same day that the ticket was issued. However, given the size of some dispensary districts, this made it impracticable for relatives or friends of the sick poor who lived a significant distance away to seek a visiting ticket. Therefore, the concept of eligibility in issuing the relief tickets and the geographical impracticalities occupied much of the debate concerning the efficiency at which patients could access health care provision during this period (Cox, 2010: 68).

When contemplating the nature of health service provision for the black ticket (E-1) class of patient, there was a significant disparity in the experience of the ‘public’ by comparison to that of a ‘private’ fee-paying patient. For instance, the dispensaries where the poor queued to see a medical physician left much to be desired. Essentially, few of the dispensaries were purpose built as the normal practice was to rent a room in a small house within a town or village whereby the poor would attend for treatment at fixed dispensary hours. This was significant when put in contrast to the experience of private patients who were treated in the doctor’s home/personal surgery. As such, this differential treatment of public and private patients rested on a societal discourse emanating from so-called ‘respectable’ people holding a fear that they would catch an
infectious disease from the poor and thus should be treated separately (Barrington, 1987: 11).

Despite the inadequacies evident, there was a willingness to maintain the system. However, this did not translate into developing the system to the standard required by the new generation following the famine. Notwithstanding, the issues of inequality and inefficiency associated with access to health care services, it is undisputable that the enactment of the Medical Charities Act, 1851 and establishment of the dispensary system marked a revolutionary shift in the manner health care was to be delivered and administered in Ireland moving forward. As McDonagh surmises;

“If one takes policy and structure as the criteria, Ireland had one of the most advanced health services in Europe in the first half of the nineteenth century. It was to a large degree state supported, uniform and centralised. It aimed at providing the poor – that is, the huge bulk of the population – with some security against both minor and major illness and at rationalising and specialising the hospital services” (1968: 27 cited in Cassell, 1996: 16).

4.3.7 Summary of key developments during this critical juncture.

- Medical Charities Act, 1851 represented a revolutionary shift in the development of health care provision. It signified a move towards state intervention through shifting responsibility from philanthropy and private initiatives to the state in health service provision. This essentially integrated the dispensary system into the wider Poor Law institutions. Hence, the Medical Charities Act, 1851 was symbolic of the ‘passing of the old order’ and the recognition of the ultimate failure of a laissez-faire approach to government policy. As a result, for the remaining seventy years of British Rule over the entire island of Ireland, the movement towards greater state involvement and increased centralisation of the health services was going to continue.

- Notwithstanding the anomalies recognised surrounding the laissez-faire doctrine, this critical juncture marked the continuation and further development of the concepts of deserving and undeserving poor established during the Poor Laws era. Under the Medical Charities Act, 1851 this concept of eligibility of entitlement was developed further through the existence of the black (E-1) and the red (E-2) respective tickets in receiving ‘public’ health care provision. As such, this
effectively began to formalise the distinction in the patient status of a ‘public’ and ‘private’ patient. Hence, this critical juncture paved the way for the foundation and evolution of the ‘two-tier’ system of access to health service provision.

4.4 Critical Juncture Three – The National Health Insurance Act, 1911.
The critical juncture surrounding the enactment of the National Health Insurance Act, 1911 represented a period in which considerable ‘change’ in the policy trajectory of health care provision became possible. This was in response to the social reforms initiated by a dynamic liberal government that came to power in 1906. The social reforms were novel to the British experience in this field of legislating in that attention was now being given to granting the working class protection against poverty. In the Irish context, the concept of social insurance was sparsely discussed in the policy discourse, which meant that the liberal reform agenda came as a shock to the system. From the perspective of the Irish health care system’s evolution, this section is going to evaluate the underlying cultural, political and socio-economic factors which influenced the development of this transformative welfare state measure. Furthermore, it will be depicted how its outright rejection in Ireland firmly established that health care was not going to be universally provided moving forward.

4.4.1 The emergence of ‘New’ Liberalism: a ‘middle way’ between individualism and socialism.
The rise of the dynamic social and welfare reform measures introduced between 1906 and 1914 owes its origins to the work of a group of liberal intellectuals who from the 1880’s set out to redefine the political tasks of British Liberalism with a particular emphasis on the need for social reform. Consequentially, this new strand of thinking led to an ideological shift in liberalism, which came to be termed ‘New Liberalism’. From the 1880’s, the ‘New’ Liberals began to redefine liberalism in response to the changing economic, political and social circumstances. There were two aspects which represented a particular focal point to these liberal intellectuals. The first, was the series of electoral defeats that threatened their political power through the electoral challenge put forward
by the socialist or social democratic parties which were on the rise across Europe during this period. This political risk to the liberals’ electoral base stemmed from the rise of working-class support for the emerging Labour party. Additionally, British liberalism was also split into a number of fragments, each of which was primarily concerned with redefining and reconstructing the political future of liberalism. One such element was the relationship between the state and the individual. This proved to be a relationship which has significant resonance in British political culture and in how we interpret ideologies of welfare in particular (Clarke et al., 1987: 35).

The second attribute was the growing body of evidence pertaining to poverty, destitution and human misery in British society during this period. In this context, the academic studies conducted by Henry George’s Progress and Poverty (1881) and Charles Booth’s The Life and Labour of the People of London (1889) raised new questions about the relationship between poverty and the economic organisation of British society (cited in Clarke et al., 1987: 36). The evidence and argumentative positions put forward in studies such as these challenged the central presumptive strands of laissez-faire views on poverty, namely that individuals were personally responsible for the misfortune experienced in their lives. Thus, the New Liberals social reform programme represented a significant shift away from this ideological stance in that it acknowledged the individual as part of and not subservient to the state. While New Liberals maintained some idealisms associated with the traditional liberal approach to individual freedom they nevertheless recognised that economic circumstances can pose as a potential inhibition to an individual’s ability to achieve and make use of the benefits of freedom. Hence, this led the New Liberals to develop a conception of ‘equality of opportunity’ which ensured that all members of society had a base through which they would be enabled to benefit from individual freedoms (Clarke et al, 1987: 36).

The New Liberals acknowledged that enforced poverty was just as unreasonable as state interference and that it could act as an inhibitor to individuals living freely. Hence, in terms of the relationship between the ‘individual’ and the ‘state’, the New Liberals reconstructed a very different view to that offered by the laissez-faire ideological perspective. For example, where the laissez-faire proponents saw a direct opposition between the interests of the individual and those of the state, the New
Liberals advocated for a more ‘organic’ view of this relationship. As such, they acknowledged that the state should not be recognised as an alien power set against the ‘free individual’ but rather it was the ‘collective power’ of society and as a duty should promote the whole of society and its members (Clarke et al, 1987: 37).

Furthermore, the extension of the electoral franchise had the ultimate effect of the state becoming increasingly open to public scrutiny from non-aristocratic groups – particularly with regards to Britain’s commercial and industrial bourgeoisie and middle classes. From this altered interpretation of state responsibility, it was made possible for the New Liberals to claim that the state could and should be utilised as a vehicle for social reform. The central object of which would be to improve the conditions of the weakest and the poorest and in turn facilitate full participation in society. Additionally, collective provision was seen to reinforce a safeguard against disasters – whether these disasters are natural (sickness) or social (unemployment). More significantly however, it enabled a means of diffusing some of the more fundamental threats stemming from, the growing link between the increasing demands of organised labour and socialist ideals (Clarke et al, 1987: 37-38).

As such, the political history of liberalism in the twenty years following 1886 was dominated by two central concerns; the need to find a unifying platform for the party which would in turn have the capacity to sustain the Liberal Party as an effective force in the post-Gladstonian era and the need to come to terms with the evident growth of economic and political strength of organised labour. Thus, it was these concerns which led to the formation of ‘New Liberalism’ and to a commitment to policies of state intervention and social reform reflected in those implemented by Asquith, Churchill and Lloyd George in the years following 1906 (Powell, 1986: 369). However, the actions of the ‘New Liberals’ cannot be attributed to solely developing specific programmes of social reform. On the contrary, their endeavours were primarily devoted to producing an intellectual and political reasoning for the Liberal Party to take up the issue of social reform and become more ‘progressive’ in outlook. Central to this process, was the conceptualisation of ‘opportunity’ and the theme of ‘citizenship’ whereby the state would assume the role of safeguarding the interests of all its citizens. Hence, this contends that the state would guarantee the rights of citizens (e.g. providing a degree of
economic security) which would in turn form the baseline for their respective individual development (Clarke *et al.*, 1987: 38).

It was not until after 1905 that the Liberal government began to introduce a more coherently planned social policy programme (Powell, 1986: 375). This was evident through the introduction of old age pensions, wage boards, labour exchanges and unemployment and health insurance. These social measures combined firmly demonstrated the extent of the ‘New Liberals’ progressive agenda and the mounting pressure placed on the state to provide solutions for social problems. Despite this, there still remained to be an increasingly uneasy political relationship between Liberalism and organised Labour. This is rooted in the belief that the New Liberals did not always intervene in a manner the Labour movement would have wished.\(^{45}\) (Powell, 1986: 381).

Thus, the New Liberals marked out an ideology of welfare which stipulated a ‘middle way’ approach between individualism and socialism. This theoretical derivation is addressed by Churchill who before defecting to the Conservative party stated that;

> “Something more is needed if we are to get forward; there lies the function of the Liberal Party. Liberalism at once supplies the higher impulse and the practicable path; it appeals to persons by sentiments of generosity and humanity; it proceeds by course of moderation. By gradual steps, by steady effort from day to day, from year to year, Liberalism enlists hundreds of thousands on the side of progress and popular democratic reform whom militant socialism would drive into violent Tory reaction.” (Churchill, 1906 cited in Clarke *et al.*, 1987: 41).

### 4.4.2 The introduction of the ‘British’ National Health Insurance Act, 1911.

The ideological force of the Labour movement proved to be symbolically powerful in shaping social reform during this period. This is founded on the premise that they

\(^{45}\) The distinction between Liberalism and the ideals of organized Labour was also clearly evident when taking into account their respective views on ‘social classes’. In this regard, the Liberal Party acknowledged that the most effective manner of achieving lasting reform was through the co-operation and conciliation of the classes. This pertained that the Liberal Party was in its view ‘free’ from sectional interests which in turn enabled the party to follow a course with a degree of even-handedness to win general assent. In contrast to this viewpoint, the Labour Party through the introduction on its part of a ‘class’ element into politics, effectively institutionalized class divisions in the political system. As a consequence, this proved to be detrimental as it was evident that there was a long-term trend emerging towards social harmony upon which the New Liberals based their political ideals upon (Powell, 1986: 390).
represented the aspirations of the working men and women who held the belief that the two-party system had failed to represent their interests (Sullivan, 1996: 4). Therefore, the introduction of the British Health Insurance Act signalled an attempt by the Liberal Party to satisfy the major grievances of the working people and thus offset the growing momentum of the Labour Movement.

The British system of social insurance was initially envisaged by David Lloyd George in his capacity as Chancellor of the Exchequer. From the outset, Lloyd George wanted to establish a system which would give reasonable protection against medical costs and loss of income due to sickness and unemployment. As such, this demonstrated a vision in which working people would be aided in respect to the additional costs associated with childbirth and to offer protection against the consequences of tuberculosis (Barrington, 1987: 35). As Thane surmises;

“Lloyd George saw ill health as the next major problem to be tackled. Hence, almost immediately after the Pensions Act was passed, Lloyd George set off to Germany to investigate the longest established national insurance system.” (1996: 78)

From Germany, Lloyd George requested civil servants to explore the means of establishing a similar system in Britain. With regards to the collection of contributions and payment of benefits – it was placed on existing organisations already experienced in such work, for instance: the Friendly Societies; trade unions; and certain commercial insurance companies (Thane, 1996: 78). Additionally, it was envisaged that the scheme would contain a compulsory element whereby the workers would make a contribution in parallel with the part contribution made by the state (Barrington, 1987: 35). In line with much of the Liberal social legislation, the scheme was grafted onto and worked closely with existing voluntary institutions; whilst the overall administration of the overall scheme was placed under a National Insurance Commission established in 1912 (Thane, 1996: 78).
The National Health Insurance Bill, as delivered in May 1911, provided for two main categories of contributor; compulsory and voluntary. In terms of the assistance received, the initial benefit a contributor would be entitled to was ‘medical benefit’ (Barrington, 1987: 36). Furthermore, contributors and their dependents were also eligible for free treatment in tuberculosis sanatoria, tuberculosis of which was a major cause of ill health and death among adults during this period. However, the contributors to this scheme were not entitled to free hospital treatment for any other purpose. The central reasoning for this was based on a belief that if the needs of the 15 million insured persons were to be met, this would in effectively overburden the voluntary and Poor Law hospitals (Thane, 1996: 78-79).

The scheme also entitled contributors to a number of ‘benefits’. For instance, a ‘maternity benefit’ as a means of covering the costs accrued with medical and nursing attendance at childbirth. Additionally, insured workers would also be eligible to ‘sickness benefit’; if unable to work as a consequence of illness. In the event of the insured being still unable to work at the end of a six month period, they would be granted a permanent ‘disability benefit’. Thus, the benefits highlighted the minimum at which a contributor was entitled and what the agencies associated with implementing this piece of legislation were obliged to provide (Barrington, 1987: 36-37).

To surmise, the health insurance act in principle fulfilled the intention of the Chancellor, Lloyd George, which was essentially to provide social insurance in times of illness. This is reinforced further in the provisions outlined in the second part of the Bill which gave some protection against unemployment and thus represented a major step towards freeing the working class from destitution due to circumstances beyond their control. Hence, the primary incentive of this scheme was the manner in which it averaged the risks of illness, unemployment and childbirth throughout the insured’s life and throughout the community. Essentially, this contained that the worker would be

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46 In the context of compulsory contributors, this included wage earners between 16-65 years of age whose contributions would be deducted from their wages each week by their employers (Barrington, 1987: 36) (Thane, 1996: 79). In the event of self-employed workers wanting to contribute to the scheme, they could do so as voluntary contributors through paying both the worker’s and employer’s share of the contribution. Furthermore, the scheme did not place an upper income limit on manual workers who would be compulsorily insured or for voluntary contributors (Barrington, 1987: 36).
afforded protection and society as a result would benefit from a decline in poverty and
dependence on the Poor Law system (Barrington, 1987: 37). 47

4.4.3 Contextualising the ‘British’ Health Insurance Act, 1911 within the
framework of Welfare State development.
The origin of social health insurance represents a significant advancement from the Poor
Laws critical juncture in that it demonstrates the state taking an ideologically justified
role in the welfare intervention of its people. This critical juncture thus demonstrates an
early aspiration in welfare provision with clear objectives. As Briggs defines;

“A welfare state is a state in which organized power is deliberately used (through politics and
administration) in an effort to modify the play of market forces in at least three directions – first,
by guaranteeing individuals and families a minimum income irrespective of the market value of
their work or their property; second, by narrowing the extent of insecurity by enabling individuals
and families to meet certain ‘social contingencies’ (for example, sickness, old age and
unemployment) which lead to otherwise to individual and family crises; and third, by ensuring
that all citizens without distinction of status or class are offered the best standards available in
relation to a certain agreed range of social services” (2006: 18).

In terms of delivering the objectives outlined in this definition, the first and second
aspect may be delivered, in part by what used to be described as the ‘social service
state’; a state in which communal resources are deployed to abate poverty and to assist
those that are in distress. However, the third objective goes beyond the parameters of the
‘social service state’ in that it brings to the fore the conceptual ideal of the ‘optimum’ as
opposed to the old conception of the ‘minimum’. As such, the ideal of the ‘optimum’ is
not merely concerned with the abatement of class differences or the needs of scheduled
groups. On the contrary, it is primarily concerned with equality of treatment and the

47 Notwithstanding this derivation, it is important to point out by comparison to modern welfare measures
and despite the benefits for those insured, the contributions failed to provide for the dependants of the
contributors. The central reason for this rests on the fact that Lloyd George received assurances from his
civil servants who held a perception that healthier male workforce would be succinctly able to provide for
their wives and children and in a contradictory sense that lower-paid workers would be unable to afford to
pay contributions to cover their families (Thane, 1996: 80).
aspiration of citizens as voters with equal shares of electoral power (Briggs, 2006: 18). Therefore, when applying the definition to the social insurance scheme of 1911, it is evident that the British were effectively cementing the stepping stone to what was inevitably going to lead to greater state involvement in upholding the welfare of its citizenry.

4.4.4 The National Insurance Act, 1911 – the Irish Dimension.
While the National Health Insurance Act proved to be a significant milestone in meeting the needs of the working classes for its time, its application to Ireland however proved to be contentious. It was envisaged that the financial structure – both the unemployment insurance and national health insurance – would also be introduced in Ireland. As such, the scheme was to be managed, under the supervision of an Irish Insurance Commissioner, by approved societies such as the trade unions, friendly societies and insurance companies. Essentially, this entailed that the new statutory system of health insurance would be grafted onto the existing structure of voluntary organisations (Powell, 1992: 144).

The proposals to improve the health of the Irish population provoked significant political unrest in Ireland. However, the Labour movement was predictably enthusiastic with one of its foremost leaders, James Larkin, declaring that the National Health Insurance Bill was “going to do more for the working-classes of this country than any measure hithertofo ore introduced” (cited in Powell, 1992: 145). Although, and perhaps more predictably, those who represented the business sectional interests, such as employers, were strongly opposed on the grounds that the Bill was symptomatic of a measure aimed at imposing a ‘penal taxation’ on the Irish people. This latter view proved to be significant in being displayed in the media as a means of turning public opinion against the bill (Powell, 1992: 145).

4.4.5 Attempts to introduce the National Health Insurance principles Ireland.
From the Irish perspective, the Liberal government became dependent on the Irish Party for support in the drafting and application of the Act to Ireland. Although the leader of the Irish Party, John Redmond, considered aspects of the social legislation to be
extravagant and unsuited to Irish conditions, he could not withdraw support from the Liberal government. Therefore, the Irish Parliamentary Party represented the people’s interests in the drafting of the Bill. While the position of the Irish Party proved to be ambiguous, the Bill was nonetheless recognised by Redmond as; “a notable and magnificent effort...to deal with the very worst of our social grievances” (cited in Barrington, 1987: 39) (Powell, 1992: 145). As a response to the social legislation, the Irish Party thus established a committee to prepare amendments as a means of modifying the Bill’s application to Ireland (Barrington, 1987: 40).

4.4.6 The Irish Clauses: Section 59 of the National Health Insurance Bill.

It appeared from the outset that no significant consideration was granted to the Irish conditions until Lloyd George instructed officials to get the assistance of the Irish office to advise the Treasury on adopting the provisions of the social insurance measure to Irish local government. The Irish situation proved to be very complicated, with the item of medical benefit being the primary difficulty. This was due to the fact that there was a widely held perception that the social insurance model was not sufficiently suited to a landscape where there were few friendly societies and where a dispensary service already provided free medical care for those who potentially would be insured under the new Act. Despite this, the Irish conditions were agreed with the Chancellor and finalised just two days before the Bill was introduced to Parliament (Barrington, 1987: 40).

The Irish conditions were contained in section 59 of the Bill. From the inclusion of this section, it was clear that the government was not going to carry out a radical reorganisation of Irish general practice in response the introduction of medical benefit. On the contrary, it was envisaged that the dispensary service would be left in place with the insurance scheme being grafted onto it. In terms of contextualising how the Irish population were to benefit from the insurance scheme, Irish workers (who were a minority) as members of the friendly societies would receive their medical benefit in a similar fashion to those in Britain. However, a separate system of medical benefit existed for deposit contributors. Within this category, the individuals would be treated
by dispensary doctors who paid a yearly sum ‘as may be prescribed’ by the health committee\(^4\) (Barrington, 1987: 41).

Despite there being no official government figures for the number of persons who would be insured in Ireland, there were unofficial estimates that a range between 800,000 to 1.3 million people would become eligible to be insured\(^5\). As such, the biggest group that were to be affected by the compulsory elements of the Bill were generally: agricultural labourers; domestic servants; industrial workers; and shop assistants and commercial clerks in private business (Barrington, 1987: 42).

In terms of the general public reaction to the Bill in Ireland, the response was exceedingly hostile. Generally, the humanitarian purpose of the Bill’s provisions were overshadowed by representations that the Act depicted another incidence of penal taxation imposed by a foreign imperial government without any fundamental benefit for the people of Ireland. From the perspective of the media, the *Irish Independent* newspaper which ideologically was never a radical paper, led the opposition to the Bill from the standpoint of the benefits which the insurance scheme offered (cited in Burke, 1999: 22). As such, the primary objections held against the Bill were in relation to the potential burden that would be placed on Irish industry by the contributions, the potential collapse of achieving Home Rule in Ireland and the inappropriateness of its provisos to Irish conditions. Hence, from an early stage that there were factions seeking for Ireland’s exclusion from the Bill (Barrington, 1987: 42).

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\(^4\) In this regard as Barrington observes, it is hard not to come to the conclusion that the rate for treating deposit contributors would be significantly lower than the rate agreed between the medical profession and the government for treating members of approve societies. By virtue of the fact that most of the Irish working population at this time were deposit contributors, it was evident that medical benefit would be provided at a reduced cost. Therefore, the bargaining power of the dispensary doctors, as a consequence, was weakened by the provision that remuneration would be ‘fixed’ by the rates; or ‘prescribed’, and not ‘arranged’ as in the main text of the Bill. Furthermore, one of the most significant and most contentious consequences of the Bill was that the private practitioners would be excluded from treating deposit contributors (Barrington, 1987: 41). This in effect would have resulted in a major drop in private practice in Ireland.

\(^5\) The Bill did however; exclude individuals employed in the public sector such as the army and navy, teachers, civil and public servants and also persons who are employed without payment by small farmers. In addition, those who were employed in non-manual jobs were also exempted from the compulsory elements of the bill, although if they so wished they could become voluntary contributors. In terms of those who were self-employed, which represented a relatively large group in the working population in Ireland, were also exempted from compulsory contribution, though they too could become voluntary contributors (Barrington, 1987: 42).
4.4.7 The Irish Medical Profession: response to the Bill

It was apparent from the initial negotiations between the British Medical Profession and the government that Ireland was not going to obtain the same administrative system of medical benefit as in Britain. At a special representative meeting in London to discuss the implications of the social insurance measure, the BMA gave a commitment to ‘six points’: an income limit of £2 a week for those entitled to medical benefit; choice of doctor; the exclusion of the friendly societies from the administration of medical and maternity benefit; local flexibility in the system of paying doctors; adequate remuneration; and strong medical representation at all levels of the new administration (Barrington, 1987: 44).

In the Irish case, Lloyd George in addressing the BMA was asked if it was the government’s intention to retain Ireland under the Bill and if so, were the funds for the administration of medical benefit going to be applied equally in both Ireland and Great Britain. In responding to the question, Lloyd George avoided answering it with complete certainty (Barrington, 1987: 44). Instead, he referred solely to the dispensary system where he stated that; “In Ireland the problem is not to set up a separate independent medical attendance, but to pay the parish doctor more than he is getting now.” (cited in Barrington, 1987: 44). Lloyd George stipulated that while the same amount of medical remuneration would apply to both doctors in Ireland and Great Britain; it rested with the Irish medical profession to deliberate on its distribution (Barrington, 1987: 44).

On the part of the Irish medical profession, the central dilemma for their organisation was to fully contemplate how the provisos of the Bill affected them. Barrington (1987: 44) argues that their representative associations did not advise them comprehensively. Furthermore, the Irish Committee of the BMA also sent a letter to all medical practitioners in Ireland which: deliberately confused the distinction that existed between ‘compulsory’ and ‘voluntary’ contributions; gave no definition of the status of deposit contributors; and finally made no reference to the various exceptions of compulsory insurance. Furthermore, the letter also inferred that every person earning less than £161 a year, which at the time represented an overwhelming proportion of the Irish population, would be compelled into the insurance scheme. This had the perceived
implication of imposing a loss to private medical practice due to the capitation of fees (Barrington, 1987: 44-45)

Hence, it is palpable that the doctors who drafted the BMA’s letter were primarily concerned with the loss of private patients due to the capitation of fees rather than on the way which the dispensary medical officer could benefit from a transition to a system of insurance-funded medical treatment. In effect, this indicated the way the Irish medical profession would split on the provisions enshrined in the Bill (Barrington, 1987: 45).

The Bill had the effect of rousing the Irish medical profession. In particular it became apparent that the profession was divided on whether to reject the Bill in its entirety or to seek suitable amendments. Initially, it was the medical graduates of Dublin who called for the outright rejection of the Bill. They objected to the introduction of contract practice in Ireland. Furthermore, it was also pointed out in debates that at least one-seventh of the Irish population was already in receipt of medical relief through the dispensary service, which meant that the need for medical benefit was small. Thus, it was their view that the government should instead remodel the Poor Law medical system in Ireland (Barrington, 1987: 45).

However, the president of the Irish Medical Association (IMA) announced that the Bill, if adequately amended, would prove to be most beneficial to the Irish working people. The IMA in primarily representing the interests of the dispensary doctor’s, held a referendum on the Bill, which aimed to seek the opinion of the profession on a number of issues, of which the first five were identical to those contained in the BMA’s ‘six points’ (Barrington, 1987: 46).

To achieve the conditions outlined in the IMA referendum, representatives of the Association began to secure contact with Lloyd George, John Redmond and also the Committee of the Irish Party which was sitting in Dublin collecting information on the suitability of the Bill to Ireland. The meeting held went on to ratify the suggestions which had been presented to the referendum of the profession. In terms of the outcomes of this meeting, almost half of the doctors in the country returned their views and declared to be in favour of the suggested amendments (Barrington, 1987: 46).
It became apparent that the medical profession was committing itself to a battle with the British government and were subsequently demanding more generous terms than their British counterparts. In addition, the assembled doctors also stipulated that they would not administer the medical and maternity elements of the Bill unless the demands outlined were met. In terms of protecting the interests of both the IMA and the BMA at the negotiation’s process, a Joint Committee was established with respect to this Bill. However, this demonstration of unity hid deep divisions within the profession, even among those who were present at the meeting. It was apparent that ‘unity’ and ‘coordination’ seem to have been lacking in the medical profession’s presentation of their case. This was particularly evident in regards to the diverging viewpoints of the Irish Committee of the BMA and the General Medical Council. In concluding its deliberations, the Irish Committee observed that the arrangements for the application of medical benefit to Ireland were unworkable. By contrast, the General Medical Council argued that the deposit contributors should be given a choice of doctor and that the medical service for those who are insured should be delivered distinct from the dispensary service (Barrington, 1987: 46-47).

In responding to the position of the medical profession, in a document leaked to the Westminster Gazette, Lloyd George threatened members of the Irish medical profession that if they were unreasonable in their demands, a state medical service for insured workers would be established. Retrospectively, this proposal would have been suitable in the Irish context as the duties of the employed doctors could have included in its remit the treatment of those too poor to be insured as well as insured persons whereby provisions could also have been made for the dependents of insured persons. Essentially, the system would not have been radically different from what had existed previously in that patients outside of the scheme of insurance who could afford it would continue to pay as before \(^{50}\) (Barrington, 1987: 47-48).

\(^{50}\) Therefore, the medical profession would have stood to gain greatly under this transformation of the health services in Ireland. For instance, this could have led to the profession could have been recruited on the basis of open competition and enjoy the same conditions of service as officials in the civil service and medical officers in the army and the navy (Barrington, 1987: 47-48).
Despite this, the primary opposition to the insurance scheme stemmed from the doctors who operated in large private practices and feared the loss of fee-paying patients to the insurance scheme, of which remained to be a predominant issue. However, while these doctors were influential, they represented only a small proportion of the profession and were significantly outnumbered by dispensary medical officers. Conceivably, in an attempt to ensure solidarity with the British medical profession, the Irish doctors ceased to explore further the possibility of introducing a state medical service. Through letting this opportunity slip, the Irish medical profession effectively allowed itself to hold out for demands which were articulated for a British medical profession and healthcare system. In addition, they also gave away a tactical advantage point in appearing to be avaricious on questions of remuneration and conditions of service (Barrington, 1987: 48).

Essentially, this failure also resonated within the political system. It was apparent in Westminster that the Irish position was not considered to be of paramount importance, to the extent that the Treasury did not consider the application of the scheme to Ireland until very late in the preparation stages of the Bill. Therefore, there was little knowledge of the conditions for Irish doctors. It relied on the Irish Parliamentary Party and the Irish medical profession then, to resolve its own difficulties with this piece of legislation. However, the single greatest impediment to the introduction of this social insurance measure to Ireland stemmed from the Irish Parliamentary Party. While they accepted in principle that this iconic piece of legislation would benefit Ireland, they could not campaign too vigorously for acceptance of the British measure unless it was Home Rule (Barrington, 1987: 48). This signalled that nationalistic ideals during this period overruled a measure designed to address the physical health of the nation’s people.

4.4.8 The intervention of the Irish Catholic Hierarchy.
One of the most interesting aspects to note was the intervention of the Catholic hierarchy, which during this juncture overshadowed the medical profession as an effective vested interest. The Irish bishops acknowledged the virtues of the social insurance measures for an industrial England and Wales but considered it inapplicable to
the interests of a predominantly rural Irish populace (Powell, 1992: 146; Barrington, 1987: 49; Adshead and Millar, 2003: 11). Additionally, they criticised the ‘change’ which required parents to insure their sons and daughters over the age of sixteen working for them on large farms, shops and public houses and thus would account for the majority of those to be insured (Barrington, 1987: 49).

Hence, the hierarchy held the view that the contributions would be oppressive in nature and could not be justified by the medical benefit received. Furthermore, they also perceived that individuals could receive the same level of medical service under the existing dispensary system. By implication, the Church failed to acknowledge the potential benefits of the Bill in respect to the provision of maternity, sickness or sanatorium benefit to which all workers would have been entitled or to the unemployment insurance which men within the building and engineering sectors could claim (Barrington, 1987: 49).

Due to the fact that 800,000 industrial and domestic workers in Ireland were to benefit from the Bill, this highlighted that the Catholic Church’s position was somewhat unfounded. Moreover, had the self-employed joined the scheme, as many as 1.3 million, according to unofficial statistics, were deemed to benefit considerably (Powell, 1992: 146). Nonetheless, the Catholic episcopacy recommended to the Chancellor in their statement, that Ireland be excluded from the remit of the National Insurance Bill. Instead the Church recommended that the Liberal government set aside the state contribution necessary to fund the scheme in Ireland either in the form of designing an insurance scheme which would specifically addresses the needs of the country or for some other purpose that would prove to be beneficial to the general welfare of the population (Powell, 1992: 146; Barrington, 1987: 49). The hierarchy also ended with a request to the Irish Party to urge this line of policy on the Liberal government.

The intervention on the part of the Catholic Church is interesting on a number of fronts. Most significantly, it represented the first time that the hierarchy initiated a condemnation of government policy. In this regard, the Irish hierarchy’s statement demonstrated that the Bill was analysed from the discourse and mind-set of a predominantly rural and capitalist viewpoint and also the perspective of the farmer and small trader. Hence, the Church did not acknowledge desperation and destitution of the
working class people who lived in the cities. Therefore, it was not fully comprehended
the benefits which the Bill had to offer. Furthermore, the lack of sympathy with regards
to the intentions of the Chancellor coupled with the fear of a potential financially
insolvent Home Rule government, proved to be sufficient in persuading the Catholic
hierarchy of the need to demand Ireland’s exclusion from the Bill (Barrington, 1987:
50).

In view of the subsequent controversies to occur between Church and state, the
position held by the bishops in this instance is noteworthy because it signalled the
intention of the Catholic hierarchy to pursue a temporal as well as spiritual role in Irish
society during the course of the 20\textsuperscript{th} century. Essentially, the arguments which the
hierarchy utilised were as the \textit{Irish Worker} remarked; “not based on a matter of ‘faith
and morals’ that calls for their interference” (cited in Powell, 1992: 146). On the
contrary, they were purely social and economic and their style of intervention was
highly political (Powell, 1992: 146). This is echoed further by Barrington who states
that the maternity benefit cover under the scheme was not conflicting with the moral
fibre of Irish women nor could the insurance benefits be depicted as an instrument that
would ultimately undermine the responsibility of head of the family to provide for his

\textbf{4.4.9 The enactment of the National Health Insurance Act, 1911: Ireland’s exclusion from the social insurance measures.}

In responding to the Irish hierarchy, the Irish Party had to strike a deal which would
both meet the approval of the Church and retain some of the benefits contained in the
Bill. Despite the Irish Party wanting to abolish the dispensary service, it proved to be
inevitable that a move in this policy direction would encounter one major problem, cost.
The decision to replace dispensary system would have been an appealing option to the
Irish Party if the state funding of the new system remained within the purview of the
imperial exchequer (Barrington, 1987: 51).

Furthermore, the Irish Party also realised that the funding of such a service
would prove to be more difficult if an independent Home Rule Irish government had to
meet any deficit in the financing of such a transformation in the health services. As
such, the potential of an independent Home Rule government significantly constrained the options open to the Committee regarding the provision of medical benefit. On this basis, the Irish Party issued a statement recommending that the Bill should be applied to Ireland albeit with significant exclusions and limitation. The most contentious amendment sought was the exclusion of medical benefit. In this regard, the Irish Party argued that “there is already in Ireland a system of medical relief for the poor which is, generally speaking, efficient, and is paid for chiefly out of the rates” (cited in Barrington, 1987: 51). In this announcement, the demands of the Irish medical profession were effectively cast aside. On the 9 January 1913, the Chancellor following advice from the Irish Party announced the establishment of a Committee to examine the application of medical benefit to Ireland (Barrington, 1987: 58). The Committee eventually recommended against the extension of medical benefit, but added that the State through the Exchequer should provide financial assistance to the existing friendly societies until a state medical service is established – which would indeed occur in Britain in the 1940’s during the Beveridge era but not in an independent Ireland (Wren, 2003: 29).

Adshead and Millar point out that the decision of the Irish sectional interest groups – namely the Irish Party, the Catholic Church and the Irish medical profession – not to implement the National Health Insurance Act in its full capacity effectively marked Ireland’s initial digression from a genre of health policy being adopted in Britain and continental Europe, through which social insurance based on medical benefit would become the norm in the majority of these countries (2003: 11). Therefore, while the debate surrounding free medical care did not fade away in its entirety, it is clear from this critical juncture that healthcare provision would never be universally provided in Ireland (Adshead and Millar, 2003: 11; Wren, 2003: 29).

4.4.10 Summary of key developments during this critical juncture.

- The ideological shift which occurred during the nineteenth century from Classical Liberalism to ‘New’ Liberalism marked a significant transformation in the relationship between the ‘State’ and ‘Individual’ through the expansion of the welfare state. Where in its introduction of social policy measures in the arena of
health care, education, old age pensions and unemployment this demonstrated an acknowledgment of state responsibility in the provision of social measures as a means of sustaining the welfare of its citizenry.

- The National Health Insurance Act, 1911 proved to be a central cornerstone to this expansion of the welfare state across the British Isles. For its time, this social insurance measure was revolutionary and unprecedented in the history of social provision. As it provided a level of protection for the citizenry in the area of health care, maternity care and unemployment and sickness. However, the ideological shifts occurring in Britain was not reciprocated in Ireland which led to the outright rejection of the Bill. Principally, the sectorial interests which comprised of the: medical profession; the Irish Parliamentary Party; and the Irish Catholic Hierarchy, effectively inhibited the medical benefits contained under this legislation from being extended to Ireland. The combined forces of these sectorial interests during this critical juncture ensured that the Irish dispensary system and the growing public-private mix in health care provision was to be a sustained feature of the policy trajectory. Hence, the universalist ideals contained in the National Health Insurance Act, 1911 were dismissed as a defining characteristic of access to health care provision into the future.

The critical juncture surrounding the Mother and Child Scheme proved to be a watershed moment in the politics of health care provision. As a policy objective, the scheme represented an attempt to instil universal principles of access to public health care provision. This was primarily to occur through providing free health care to mothers and children till the age of sixteen, a social measure unprecedented in the Irish experience. The scheme provoked a deep sense of unrest amongst sectorial interests namely: the Irish Catholic Hierarchy; the medical profession; and factions within the Irish states first coalition government who ultimately sought for its outright rejection. To many this measure was viewed as being an exercise of excessive state intervention; encroaching in the private realm of the family and a stepping stone down the trajectory
of socialised medicine. At this critical juncture, defeating the introduction of universal principles produced a policy outcome which affirmed the principles of ‘eligibility means-testing’ and the ‘public-private mix’ of entitlement in the Irish health care system.

4.5.1 The transition of power from Westminster to the Irish Free State: Process of Consolidation.

In understanding the social context of the Mother and Child Scheme, 1947 it is important firstly to analyse the cultural values and professing ideology held by the political elite in the newly founded state which was in turn endorsed and utilised in the derivation of public policy, particularly in the context of welfare provision. From the onset, the configuration of the Irish state and its subsequent development after independence bears the hallmarks of a post-colonial and semi-peripheral experience. In particular, the idealistic tendencies of nationalism along with the newly founded state’s economic vulnerability proved to be pivotal in shaping the role which the governing political elite would play in the newly founded state. However, of these influences nationalism proved to be the most dominant. Essentially, Irish nationalism came to represent an untypical agent of stability rather than upheaval in the newly founded state. Hence, this symbolised that ‘continuity’ rather than ‘change’ was to become a defining characteristic in independent Ireland in the early decades (Breen et al, 1990: 20).

This is particularly prevalent when analysing Ireland’s social history during this period. As Ferriter (2004: 296) argues, some significant quotes made by key members of the first Free State government demonstrate a deliberate and regressive conservative ethos present during this period. The most notable of these utterances stemmed from Kevin O’Higgins, Free State Minister for Home Affairs when he remarked of himself and his colleagues that; “we were probably the most conservative revolutionaries that ever put across a successful revolution” (cited in Ferriter, 2004: 296). Furthermore, the shadow of the civil war in conjunction with the growing levels of poverty in the country ensured that there was little appetite in the political sphere to comprehend radical social and cultural changes in the newly founded Free State (Ferriter, 2004: 296).
The conservative ethos resonant amongst the political elite during this time becomes more prevalent when contextualising the prevailing attitudes towards exchequer funding, in which the civil war had created the potential for state bankruptcy. Consequentially, this not only led to a preoccupation with the need to balance the books, but also a desire to cement a stern attitude towards what was described as the ‘undeserving poor’ in respect to social provision (Ferriter, 2004: 296).

4.5.2 Prevailing attitudes of the Free State towards policies of the Welfare State.

In regards to economic and social issues, the Irish Free State favoured an auxiliary method which emphasised strongly on the practice of non-state intervention. (Breen et al, 1990: 24). Furthermore, the nationalist struggle for independence also demonstrated a transformative approach to the manner in which economic and social policy is initiated. In particular, under the Democratic Programme of the First Dáil, 1919, Sinn Féin promised each citizen of Ireland a right to ‘an adequate share of the produce of the Nation’s labour’. As such, this reflected a comprehensive commitment to the equitable distribution of resources. Moreover, national sovereignty was declared to represent ‘all the wealth producing processes within the land and ... all the rights to private property must be subordinate to the public right and welfare’ (cited Breen et al, 1990: 24). Despite this rhetoric, the Democratic Programme was never seriously deployed as a weapon to achieve independence. Nonetheless, the Irish nationalist interpretation of social and economic responsibilities of government provides a useful theoretical benchmark of a policy paradigm which the Free-State government failed to accomplish in the initiation of economic and social policy.

This is particularly pertinent when evaluating the role of the Department of Finance during this period and also the ideological tendencies of the then Minister for Finance Ernest Blythe. Upon entering office, Blythe ensured that the new state would initiate a rigorous form of retrenchment in respect to social policy51. As such, the government’s financial policy during this period amounted to a virtual abdication of

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51 For instance, an initial practice which demonstrates this sense of retrenchment is apparent when analysing Blythe’s financial policy of reducing government expenditure from £42 million in 1923-24 to £32 million in 1924-25 and reduced by a further £24 million in 1926-27 (Lee, 1989: 108-9).
social subsistence in favour of established financial interests and the consolidation and
support for the Free State regime from members of the financial economy. While Blythe
held a clear agenda for financial management in Ireland, he had no economic policy
beyond the act of faith that prosperity would follow from fiscal rectitude. Hence, it was
professed that if finance looked after the accounts book-keeping, the economy would

This foundational manoeuvre in tackling the state’s finances affirmed a distaste
towards what members of the Cumann na nGaedheal Party seemed to regard as a
‘culture of dependency’ in welfare provision. A practice of which was not only
economically, but politically at odds with their self-help agenda (Ferriter, 2004: 314).
Thus, it is prevalent that the ethos of *laissez-faire* capitalism was a dominant
ideological force professed by the political elite during this time.\(^52\)

The development of the Irish welfare state during this period then; can be
conceptualised as being greatly influenced by its colonial past, in particular the Poor
Laws institutional structure. From this standpoint, the Irish welfare state in the 1920’s
pursued a trajectory of social provision which was in outlook, quite minimalist.
However, when taking into context the economic and social environment of the time,
Ireland inherited a system from the UK that was more developed than might be
expected. The relatively sophisticated system of social provision, discussed above in
respect to the Liberal government’s reforms, was clearly not consistent with the regime
of free trade and fiscal liberalism inaugurated by the Cummann na nGaedheal
government upon the granting of Irish independence (Cousins, 2005: 98). Hence, this
affirms that the initial government of the Free State was directing its efforts towards
cutting the welfare system down to a size and in the process make it more consistent
with their vision of fiscal and economic policy.

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\(^52\) A primary example which demonstrates this ethos was the position held by the Free State government
on agricultural policy. The functioning of the entire fiscal economy relied heavily on agriculture as an
engine of economic growth in the country. Patrick Hogan, in his capacity as Minister for Agriculture, was
the primary architect of the public policy initiatives in this regard. Interestingly, the central crux to Hogan’s
ministry was a philosophy that ‘national development in Ireland, for our generation at least, is practically
synonymous with agricultural development’. This had the ultimate consequence of linking the fate of the
country’s economic development to the success of the agricultural industry (Lee, 1989: 112).
In the planning of social policy, the Cummann na nGaedheal cabinet took the viewpoint that those who found themselves in destitution were responsible for their own impoverishment. As such, this reflected an *individualist* ideological viewpoint, whereby the poor should pay for their lack of moral fibre. The existing distribution of income, and indeed of opportunities, to a large extent was perceived to satisfy the overarching demands of social justice. It is interesting to note that despite O’Higgins once declaring that ‘the welfare and happiness of men and women and the little children of this nation must, after all, take precedence over political creeds and theories’ the Cosgrave government once in power would initiate an *iron style* approach to social provision (Lee, 1989: 124).

Upon being granted independence, the government introduced Poor Law legislation which had the ultimate effect of substituting what was described in the Democratic Programme of the First Dáil, 1919 as ‘the present odious, degrading and foreign poor law system’, with an equally odious degrading native system of social provision (cited in Lee, 1989: 124). In this context, it is clear that the government believed in ‘strong’ and ‘ruthless’ style of governance. As such, any ideals professed pertaining to a social welfare utopia were rigorously dismissed53 (Foster, 1988: 519). Hence, the attitude towards social provision in Ireland was still living in the shadow of the former workhouse system. This was reflected in the mentality it induced with regards to its discrimination against the sick poor, those suffering from TB, unmarried mothers and deserted and orphaned children. It is in essence ironic that in the introduction to a report of the inquiry into the sick and destitute poor published in 1927, W.T. Cosgrave suggested that ‘the condition of a nation’s poor indicated the character of the nation’s mind’ (cited in Ferriter, 2004: 325). However, in truth there was a frequent tendency to see poverty as representing a flaw in the national character: a lack

53 For instance, unemployment and other labour benefits remained minimal and pegged at pre-1922 levels. These Spartan measures are symptomatic of an adjustment to the realities of the fiscal autonomy; of which the resources of the newly founded Free State could nowhere near fund in accordance with the levels laid down by successive imperial governments since the Liberal administration of 1906 (Foster, 1988: 519). However, the most contentious aspect of social provision during this time was the decision to reduce the old age and blind respective pensions in 1924. In this context, the cutting of the old age pension by a shilling in 1934 reflected the Minister for Finance’s determination to balance the budget books, regardless of the social cost to the Irish people (Lee, 1989: 125).
of thrift, independence or of ‘manly desire’ to want to earn a living (Ferriter, 2004: 325). Therefore, in this context, it is evident that the newly founded state professed a political ideology which held the central traits consistent with the laissez faire economic orthodoxy. Furthermore, its staunch non-state interventionist stance on social policies demonstrated an infusing of individualism in the fabric of Irish society.

4.5.3 Church and State: Determinants of the Political and Societal Structure in post-independence Ireland.

In a similar fashion to the ambitions of the political elite, the Catholic Church in the 1920’s also sought to reinforce the legitimacy of the new state (Keogh, 1994: 28). The political climate of the Irish Free State suited and reassured members of the Catholic hierarchy which at this point lived and survived the revolutionary period where socialists’ idealisms were rampant. In reflecting upon the crucial role which the Church played in securing the state’s legitimacy, Tom Garvin provides a succinct analysis where he states:

“…the Catholic Church was an almost proverbially popular and powerful organisation, controlling the educational system, much of the elite culture, and, for many, but not all, purposes, the mind of the collectivity. Irish Catholic political culture took its religion from Rome, but its politics from a curious and mongrel mixture of Herder, Pearse, Marx, Irish historical memory, English liberalism, American constitutionalism and, in particular, Daniel O’Connell, the often unacknowledged father of Irish Democracy. The result was a curiously empty rhetorical democratic radicalism or national populism, behind which abided a deep, unselfconsciousness and unexamined commitment to liberal democracy and an equally deep and commonly unexamined conservatism.” (2004: 24).

From the onset, the Catholic Church enjoyed a close relationship with members of the Cumann na nGaedheal government, to which the political elite acted in a subservient manner within that partnership of Church and State. The promotion of socialist philosophical ideals such freedom of consciousness, provided a precursor for the Church to exercise stringent moral authority in the post-independence era. The role of the state in this framework was to perform simply as an instrument through which such moral authority could be implemented.
Towards the latter years of the 1920’s, the Church’s influence was beginning to rise in the political and social spheres. Sean O’Faolain describes the revival during these years as representing ‘a time when the Catholic Church was felt, feared and courted on all sides as a dominant power’ (cited in Whyte, 1980: 35). Hence, the restrictive legislation introduced on censorship\textsuperscript{54}, the curtailing of drinking hours and the blocking of divorce did not stem from the demands of Catholic laypeople. On the contrary, the successful enactment of these initiatives firmly occurred in response to the Bishops and political elites’ conservative outlook (Keogh, 1994: 29).

The consolidation between the political and ecclesial sphere was reinforced further through the then Taoiseach W.T. Cosgrave’s establishment of diplomatic relations with the Vatican in 1930. This was significant in that it provided a virtual ‘papal seal of approval’ of Cosgrave and his government. While Cosgrave was engaging in a process of consolidation, Eamon de Valera, as the founding leader of the Fianna Fáil Party was attempting to restore relations with the Catholic Church following much clerical hostility during the Civil War period (Lee, 1989: 160). Upon rising to power de Valera set out to demonstrate that anything Cosgrave could do in upholding the spiritual line, he could do better. Therefore, from this analysis it appears that the two major parties in the Irish State, Cumann na nGaedheal and Fianna Fáil, while being bitterly divergent on constitutional and economic issues, they were at one when it came to Church-State relations\textsuperscript{55} (Whyte, 1980: 60).

\textbf{4.5.4 The Mother and Child Scheme 1947: banishing the ideal of universal coverage from ever being established in the Irish healthcare system.}

The analysis of the social and political fabric surrounding the establishment of the newly founded Free-State provides an understanding of the cultural frameworks applied by policy and political actors combined. However, it is from the controversial debacle surrounding the Mother and Child Scheme, 1947 that a true and concise reflection of the

\textsuperscript{54} Censorship of Publications Act, 1929.

\textsuperscript{55} For instance, Cosgrave’s government refused to legislate on divorce, de Valera’s government made it unconstitutional. On other social issues, Cosgrave’s government regulated films and books and forbade the propaganda for the use of contraceptives; de Valera regulated dance halls and banned the sale and import of contraceptives (Whyte, 1980: 60).
institutional norms and values in operation can be analysed. Therefore, the primary objective in analysing this period is to explore how the conflict between policy actors and vested interests has been shaped by incentives, opportunities and the constraints that were present. During this watershed moment in the evolution of the Irish health care system, there was more than one course of action possible. Furthermore, the unfolding of events was just as dependent on historical accident and the inventiveness of these actors as they were on the institutional constraints which presented themselves during what was to become an iconic clash between Church and State.

4.5.5 Reforming the Irish health care system in the 1940’s: Fianna Fáil’s attempts at Health care reform and the influence of the Catholic Church.

The marked increase of state intervention in the Irish health care arena to a large extent was in response to the falling numbers in religious vocations along with the increasing complexity and costs associated with the growth of modern medicine. Thus, it was no longer feasible for religious institutions to sustain control in the Irish health services. This provided the impetus for the state to intervene as it was believed that only public finances could cater for the expanding scale of medical and paramedical personnel necessitated in health service provision\(^{56}\) (Browne, 1986: 141).

Prior to the state’s first inter-party coalition government coming to power, the Fianna Fáil government initiated a reform agenda of the Irish health services. Under the Ministerial leadership of Dr. Conor Ward, the Department of Local Government and Health introduced a radical blueprint for reform of the health services. There were two key areas identified in the reform: to tackle infectious diseases; and to provide better welfare care for mothers and children. The shift towards state or communal medicine was reflective of trends that were occurring in Britain through the Beveridge Report which sought to: eradicate the enemies of public health; disease; ignorance, loss of income, squalor and idleness (Cooney, 1999: 254).

The most contentious aspect of this health care reform Bill was the sections which concerned the introduction of the free mother and child welfare scheme. Through

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\(^{56}\) Due to the hospitals at this point in time being archaic and ill-equipped to a level which was detrimental to a patient’s health this in turn justified state intervention (Browne, 1986: 141).
the intervention of the Archbishop of Dublin, John Charles McQuaid, de Valera was informed that the Catholic Church’s primary concern was with what he regarded as;

“the unusual and absolute power of medical inspection of children and adults, by compulsory regulation, and, if needs be, by force, is a provision so intimately concerned with the rights of parents and the human person, that only clear-cut guarantees and safeguards on the part of the Government, can be regarded as an adequate protection of those rights.” (cited in Cooney, 1999: 254).

In acknowledging McQuaid’s strong control of the Dublin hospitals and his influence with the medical profession, de Valera was swift in his attempt to diffuse the concerns of the Catholic Church. In response, the Minister, Dr. Ward, assured McQuaid that at committee stage deliberations on the Bill, amendments would be introduced exempting the inspection of ‘better-type school children’ who possessed a certificate from the family doctor. Subsequently, McQuaid approved of the amendments introduced by Ward (Cooney, 1999: 255).

Prior to the Bill reaching the final stages of enactment, Ward fell from power due to a scandal involving irregularities in his tax returns. Thus, it was left to his successor, Dr. James Ryan to continue the health reform agenda. In 1947, he introduced a Health Bill which was identical to Ward’s Bill in that it put to the forefront the importance of establishing a comprehensive service for mothers and children up to the age of sixteen years free-of-charge. At this point in time, there was no objection on the part of Dáil deputies and the bill was enacted in August 1947 (Cooney, 1999: 255).

However, the Bill did not pass without controversy. Initially, James Dillon T.D. challenged through the courts, the constitutionality of provisions in the Act granting the power to Local Authorities to compel children to undergo medical inspections. While the Catholic Church also made further objections in respect to section three of the Act. This section empowered a public authority to provide for the health of all children, to treat their ailments, educate them in relation to health, educate women in respect to motherhood and provide all women with gynaecological care. In the Catholic Church’s view, the granting of such unqualified powers to the state was contrary to Catholic teachings; the rights of the family; the rights of the Church in education; the rights of the
medical profession; and the rights of the voluntary institutions. In responding to the letter sent to him privately, de Valera assured the bishops that the government fully respected the fundamental personal and family rights. He also included in the letter a memorandum of Minister Ryan’s alterations, which he drafted following consultations with McQuaid. However, as this letter was sent two days before de Valera departed the office of An Taoiseach, it was going to fall on the Inter-Party Coalition Government, and in particular Dr. Noel Brown as Minister for Health, to offset a clash emerging between Church and State (Cooney, 1999: 255-256).

4.5.6 The Irish State’s First Inter-Party Coalition Government: Social Reform and the principle of subsidiarity.

During the post-war years, the conceptual ideal of the welfare state had begun to attract attention in the political sphere. This would prove to be an issue which the coalition government led by Fine Gael and also a left-wing element consisting of Labour and the newly formed Clann na Poblachta Party would have to contend with during their tenure in office. In terms of social policy making, the new government proved itself to be more adventurous than its predecessors Fianna Fáil. However, its reformist approach to social issues was to prove contentious, as the coalition government went into direct conflict with Catholic social teaching which had defined the role of the State to be a subsidiary one (Powell, 1992: 231). The influence of the Catholic Church in the arena of social policy in Ireland can be defined under two broad headings: a teaching influence, derived from Catholic social thought; and a practical influence which arose from the Church’s position of being a major provider of social services. In terms of the evolution of the Irish healthcare system, the latter of these influences proved to be the most significant. As such, the Church developed a large practical role in the provision of social services before it evolved anything resembling a formal body of social teaching. However, its formal teaching in the social field never corresponded to the inventiveness or impact of its social provision57 (Fahey, 1998: 411).

57 Among its greatest achievements in social service provision was the development of Catholic schools, hospitals, orphanages, and other similar institutions which had multiplied and flourished in the course of
In terms of Church-State relations, this vision of social provision differed greatly. The central reason for this rests on the fact that the Church held a philosophy which viewed ‘negative’ state interference (i.e. police action) as permissible and ‘positive’ state intervention (i.e. welfare provision) as unacceptable (Powell, 1992: 231). This was in contrast to social attitudes in the United Kingdom which advocated for the establishment of a comprehensive welfare state based on the ideal of shared citizenship and universal entitlement to social services (Pierson, 2006: 129; Alcock et al., 2004: 31-33). In this context, the Beveridge Report, 1942 represented a ‘sustained attempt to reduce inequality through public action’ (Gamble, 1987 cited in Alcock et al., 2004: 32). As such, the establishment of the National Health Service proved to be significant as it represented a concerted attempt to provide health care on the basis of ‘equal access for equal need’ (Smith, 2009: 4). This alternate vision on social provision proved to be significant in establishing the battle-lines between social reformers and the Roman Catholic Church. Hence, the inter-party government were provoked into a momentous conflict over the nature of State intervention. Central to this debacle was the core principle of subsidiarity (Powell, 1992: 232).

The doctrine of subsidiarity refers to a dogma of government endorsed by Pope Pius XI in the encyclical Quadragesima Anno, which was disseminated in 1931. Fr. Jerome O’Leary, a leading exponent of the doctrine of subsidiarity in Ireland defined the principle to mean that “a larger and higher association should not arrogate to itself functions which can be performed with reasonable efficiency by smaller and lower societies” (O’Leary, 1954: 321 cited in Powell, 1992: 232). Furthermore, Fr. O’Leary also stated that;

“if we accept, then, as we must, this principle of subsidiarity as being of universal validity, it follows that the State, like any other society, has a specific function of its own and is not entitled to take on any function which it pleases or any function which a misguided electorate may think fit to foist upon it” (O’Leary, 1954: 321 cited in Powell, 1992: 232-33).

the nineteenth century. In many respects, the services provided were similar to those of emergent welfare states (Fahey, 1998: 413).
Hence, the State should not assume responsibility for social service provision if help could alternatively be provided through individual initiative, family assistance or voluntary association. As Fr. O’Leary succinctly puts it, “[State] intervention should always be regarded as merely a first-aid measure” (O’Leary, 1954: 61 cited in Powell, 1992: 233).

4.5.7 Noel Browne: reintroduction of the Mother and Child Scheme.

Upon becoming Minister for Health, Noel Browne exhibited a strong desire to activate the section of Ryan’s Health Act which proposed free (voluntary) ante- and post-natal care for mothers in parallel with free medical care for all children under sixteen years, without a means test (Lee, 1989: 315). As Browne points out;

“Under this scheme there would be no more doctor’s bills, no more chemist bills, no more hospital bills, no more financial fear of ill-health. The message was unanswerable. The people welcomed the prospect of funding a health care service which would be freely available to anyone who needed it.” (Browne, 1986: 154-5)

In July of 1950, the Department of Health submitted a formal outline of the scheme for a mother and child health service to the Medical Association. From the outset, the scheme aimed to provide full free medical care before, during and in the aftermath of childbirth. Additionally, the scheme was to provide an entirely free family doctor medical consultant service and, if required, free GP and hospital care for all children up to the age of sixteen years. Furthermore, visits to the home by a midwife were also to be delivered free-of-charge. Therefore, one of the primary motivating factors of the scheme was to create a fresh modelled approach to health service delivery in the public’s eyes by comparison to the delay and inefficiency associated with the dispensary service (Browne, 1986: 156). Interestingly, one of Browne’s sole supporters from within the Catholic hierarchy and Chairman of the National Health Insurance Council, Bishop Dignan declared that; “The poor law system is tainted at its roots now, as it was when introduced, of destitution, pauperism and degradation.” (cited in Browne, 1986: 156). Thus, the Mother and Child Scheme represented a positive step forward in the evolution of the Irish health care system.
4.5.8 Objections to the Mother and Child Scheme: Browne’s confrontation with the medical profession.

One of the most significant ironies of the Mother and Child’s Scheme was that at the initial stages members of the coalition government were fervent to claim political credit. For instance, Minister for Defence Tom O’Higgins, was rapid in contradicting the Clann na Poblachta Party’s claim to have originated the scheme. Whilst other members of Fine Gael were adamant in claiming that the Scheme was a government based initiative. However, as Browne points out “[t]he irony lies in the fact that just as soon as the hierarchy intervened, it ceased to be a Fianna Fáil, Fine Gael, Labour Party, or even Clann na Poblachta scheme; it became the Dr Noel Browne mother and child scheme.” (1986: 155).

In this regard, Browne was faced with confrontation from two pillared forces in Irish society during this period; the Irish medical profession and the Catholic hierarchy. Barrington (1987: 205) points out that the relationship between the Minister and the medical profession was a tense one. As the Irish medical profession were deeply dissatisfied when the government decided against imposing charges for mother and child services. In a letter wrote to the Minister, it was opposed to “the provision of Free Medical Treatment to non-necessitous persons” (cited in Barrington, 1987: 205). Hence, the profession were growing increasingly concerned with the emergence of ‘state medicine’. This sense of disconcertion resonated with the professions fear of a gradual ‘Fabian’ annexation to all medical services. From this standpoint, the Irish medical profession claimed that the perceived Fabian policy trajectory followed by the Department served to starve the voluntary services and boost the state services while at the same time degrading the autonomy of the profession through whole-time appointments and salaries (Barrington, 1987: 205).

Another crucial factor which led to the medical professions objection to the scheme was the financial implication which the health care reforms posed for doctors. As such, the group of doctors which were deemed to be the most impacted from the scheme were the private general practitioners. Due to most of the private practitioners income stemming from treating childhood ailments and mothers, this meant that private practice was threatened. Additionally, specialists and consultants were also impacted by
the scheme as they also derived their income from treating those not eligible for free treatment. Thus, Browne had not clearly specified how consultants were to be paid under the Mother and Child Scheme. Furthermore, the dispensary doctors were not fully committed to the scheme, as it was perceived that intolerable demands would be put on this sector of the profession. However, the primary concern of the profession as a whole was the fear that the scheme would lead to a full-time state medical service within which doctors would become civil servants (Barrington, 1987: 206).

The impasse that emerged between the medical profession and the Department of Health during this period was to a significant extent due to Browne’s lack of forthrightness in respect to that relationship. As such, it was evident that the personal preferences held by Browne contrasted greatly with the vision of the medical profession. As Barrington points out, Browne in his Ministerial post asserted a clear ambition to establish a ‘state medical service’ (1987: 209). This was based on his belief that money transactions between doctor and patients should not be an antecedent factor in health service provision. Therefore, this had the effect of creating significant animosities between the Minister and the medical profession (Barrington, 1987: 209).

The deterioration of relations in this context also led to the weakening of support for the Minister at cabinet level. This was primarily due to his neglect at keeping the negotiation lines open between the profession and the Health Department. Thus, this omission on Browne’s part this led to a decline in support for the Mother and Child Scheme within cabinet, particularly Fine Gael Ministers who sympathised with the profession. This sentiment was also evident in respect to Costello who previously declared that he would not be able to partake in a government that favoured or tried in any manner to socialise medicine. Furthermore, there was an evident decline from within the leadership of Clann na Poblachta in support for the Mother and Child Scheme (Barrington, 1987: 209).

4.5.9 Intervention of the Catholic Hierarchy: the Mother and Child Scheme’s conflict with Catholic Social teaching.

While from the outset, the Mother and Child confrontation between Church and State proved to be controversial, due to the Church being perceived as having overstepped its
role in society, it was also argued that the Church allowed itself to be drawn into battle by the Irish medical profession. As Bishop of Ferns, Donal Herlihy reflected “we allowed ourselves to be used by the doctors, but it won’t happen again” (cited in Wren, 2003: 38). However, McQuaid recollected on the confrontation differently where he viewed it as the Church protecting the Irish people from the perceived ravages of socialism and a socialistic welfare state (Horgan, 2000: 146).

In a similar fashion to the medical profession, Browne also demonstrated an uncompromising stance in his negotiation tactics with the Catholic Hierarchy. While it was prevalent that Browne expected a confrontation with the medical profession over the proposals surrounding the Mother and Child Scheme, he did not foresee that there would have been any opposition from the Catholic Hierarchy. Retrospectively, this had proven to be severely misguided judgement on Browne’s part (Barrington, 1987: 210).

At the Archbishop’s residence, Browne was advised by the Archbishop, the Bishop of Galway Dr Michael Browne and the Bishop of Ferns, Dr James Staunton of their objections to the Scheme outlined in a letter before its transmission to the Taoiseach. In the letter, the hierarchy stated that while from the onset it was recognised that the Scheme was motivated by a desire to improve public health, it was nonetheless in direct conflict with the rights of the family and the individual (Cooney, 1999: 258-59). As such, the position of the Hierarchy demonstrated some naivety regarding the percentage of necessitous parents in the Irish population. While the availability of statistics on poverty was minimal, it is generally projected that about 30 per cent of the population were in receipt of free medical care from the dispensary doctors. Additionally, the bishops failed to acknowledge the main arguments against ‘means-testing’ access to public provision put forward by both Dr Ryan and Dr Noel Browne. Of which both argued that a means-test criterion would deter those on the borderline from seeking medical services on the basis of a lack of affordability (Barrington, 1987: 211).

From this standpoint, Costello as Taoiseach was coming under increasing pressure from both the Irish medical profession and the Catholic Hierarchy to cease the implementation of the Mother and Child Scheme. In attempting to diffuse the situation, Costello along with James Dillon (Fine Gael) and William Norton (leader of the Labour
Party) sought to mediate between Browne and the medical profession. Within this context, Costello and Norton reassured the medical profession that socialised medicine was deeply opposed in government (Barrington, 1987: 213).

However, the medical profession reasserted their original opposition to the Scheme in stating that it represented tentative steps towards the introduction of a salaried state medical service under a central bureaucracy. This, the association argued, would effectively lead to the demise of the ‘Private Practitioner’. Hence, the profession maintained their opposition to providing free medical care for the well-to-do. Instead, the IMA recommended the introduction of an alternative Mother and Child Scheme in which each mother under a certain income threshold would be given a cash grant to spend on maternity care. At this point Browne proved to be conciliatory in attempting reconcile the Department of Health’s proposals with that of the profession. However, relations between the Minister and the profession broke down on 5 March 1951, with Browne declaring to the Taoiseach that the IMA did not wish to reach agreement (Barrington, 1987: 213-214).

Despite the opposition which stemmed from the medical profession in tandem with the unresolved objections of the Catholic Hierarchy and wavering support of cabinet colleagues, Browne proceeded in introducing the Mother and Child Scheme. On 6 March 1951, he issued a press release promising an end to ‘doctors’ bills’. Copies of the pamphlets outlining the Scheme were sent to the Catholic Hierarchy and to leaders of the other Churches. Furthermore, Browne also gave a radio broadcast on the 8 March outlining the central ethos of the Scheme to the Irish people. As a consequence of Browne’s publicising efforts, the battle-lines were ignited once again with the Catholic Church (Barrington, 1987: 214).

In the process of publicising the merits of the Scheme, Browne at this point had lost the support of his Taoiseach. As Costello famously stated to the Minister;

“whatever about fighting the doctors, I am not going to fight the bishops, and whatever about fighting the bishops, I am not going to fight the doctors and the bishops.” (cited in Wren, 2003: 38).
As an attempt to reconcile with the Catholic Hierarchy, Browne arranged to meet with Archbishop McQuaid once again. From this standpoint, he was willing to accept the Church’s teaching once the Hierarchy had made an authoritative ruling. Essentially, Brown was attempting to distinguish whether the Church’s objections to the Mother and Child Scheme were contrary to Catholic ‘moral’ or ‘social’ teaching. Of which he considered himself to be bound by the former and not by the latter. In reaching a complete understanding of the distinction between both concepts, Browne had, in secret, sought the counsel of a priest and theologian at Maynooth University, Frank Cramin. Through their discussion, it was ascertained that since Catholics in the North of Ireland could engage with the NHS without moral endangerment and with the Catholic Hierarchy not stating outright that the Mother and Child Scheme was contrary to Catholic ‘moral’ teaching, this meant that the Irish political sphere was not morally refrained from implementing this policy initiative. Notwithstanding this theological foundation, McQuaid did not acknowledge this distinction and foresaw no issue in facing down this latest challenge from the Minister. As McQuaid expressed to Costello, Catholic social teaching was simply Catholic moral teaching on social matters (Wren, 2003: 39).

On 5 April 1951, McQuaid issued another letter to the Taoiseach outlining why the Scheme was unacceptable to the Catholic Hierarchy and where they considered it to conflict with Catholic Social teaching. The letter which was read out to cabinet colleagues outlined an additional objection which asserted that due to the level of taxation required to fund the Scheme, this would inevitably compel citizens to avail of it (Wren, 2003: 39). Hence, the Catholic Hierarchy upheld their belief that the Scheme could be achieved by the vast majority of citizens through individual initiative (Barrington, 1987: 217). Consequentially then, the cabinet ministers across the political spectrum unanimously accepted the ruling of the Catholic Hierarchy that the Scheme was contrary to Catholic Social teaching and that a ‘means-test’ should be applied. As such, this diminished the ‘socialistic’ idealisms associated with Browne’s original Scheme. Within days following the cabinet meeting, Browne resigned as Minister for Health at the request of his Clann na Poblachta Party leader Sean MacBride (Wren, 2003: 39).
4.5.10 Cabinet Portraits – assessing the conflicting political idealisms of Browne and his political compatriots.

From the outset, Browne’s socialistic idealisms regarding health care provision proved to go against the grain within a cabinet that was adhering to both the conservative principles espoused by the Catholic Hierarchy and the idealism of private practice in the medical arena (Millar, 2003: 132-35). In Browne’s reflection on this period, in particular his first meeting with the Catholic Hierarchy on 10 October 1950, the logic and idealisms behind his Mother and Child Scheme is provided when he states;

“As a doctor I believed that a free health service was an essential pre-requisite to an effective and a just health service. As Minister for Health the necessitous poor, a considerable sector of our society, were my special responsibility.” (Browne, 1986: 160).

Furthermore, Browne also demonstrates that his philosophical and prevailing idealisms of social justice were in direct conflict with the views of the Catholic Hierarchy when he states;

“It was clear that the bishops would support the wealthy consultants. I felt not anger but simply astonishment that men of their profession should so blatantly side with the rich against the poor.” (Browne, 1986: 161).

In this regard, it was prevalent that the Church viewed the Mother and Child Scheme as being reflective of Browne’s perceived communist or socialist tendencies. This is particularly evident in McQuaid’s reflections on the clash between Church and State as a victory for the Church in offsetting communism;

“That the clash should have come in this particular form and under this Government, with Mr Costello at its head, is a very happy success for the Church.” (cited in Cooney, 1999: 252).

“The decision of the Government has thrown back socialism and Communism for a long time. No Government, for years to come, unless it is frankly Communist, can afford to disregard the moral teaching of the Bishops.” (cited in Cooney, 1999: 252).
Within the cabinet, the conservative idealisms professed by the Catholic Church and the power of influence stemming from the Irish medical profession came to be crystallised through the *Knights of Saint Columbanus*. As Powell points out, this organisation provided a discrete connecting link between the IMA, the Catholic Hierarchy and the members of the Inter-Party Government (1992: 256). In terms of the IMA, the Knights were connected through the Guild of SS Luke, Cosmas and Damien established in 1932. With regards to the Catholic Church, sixteen bishops were members of the *Knights of St. Columbanus* including Dr James Staunton, Secretary to the Hierarchy and an influential player in the Mother and Child controversy. At the cabinet table the Knights were represented by Richard Mulcahy, Sean MacEoin, William Norton and Joseph Blowick. Within the sphere of health policy provision, the Knights were consistent in their opposition to health care reform since 1945, which was in line with their policy of promoting Catholic social principles. Additionally, the Supreme Knight 1942-48, Stafford Johnson was deeply opposed to Beveridgian style of social reform occurring in Britain. Therefore, this rather impervious network had the potential to put Browne at a severe political disadvantage in attempting to introduce the Scheme (Powell, 1992: 256).

Another significant adversary to Browne’s health care agenda within cabinet was Minister for Defence, Dr Tom O’Higgins who was both a medical practitioner and close ally to the IMA. As Barrington points out, during the course of Fianna Fáil’s attempt to introduce a Mother and Child Scheme, O’Higgins was a staunch opponent (1987: 183). At this time, O’Higgins argued that the initiative represented a major threat to the private practice of medical practitioners in which he claimed that 70-80% per cent of their income was derived from treating young children. During Browne’s tenure as Minister for Health and in his attempts to implement the Mother and Child Scheme, O’Higgins maintained an alliance with the IMA and sustained negotiation lines between Costello as Taoiseach and the profession (Millar, 2003: 132-34; Barrington, 1987: 183, 212; Whyte, 1980: 235).
4.5.11 Assessing the fall of the Mother and Child Scheme.

As Barrington surmises, there were a number of different facets which led to the collapse of the Mother and Child Scheme (1987: 219). The primary attribute amongst these was the failure to secure the support of the government for the details of the Scheme. As such, Browne’s political inexperience came to the fore through his inability to secure agreement among the Ministers, with divergent views, from the five coalition partners. Outside government, the medical profession and the Catholic Hierarchy were aware of the divisions in the cabinet regarding the Scheme and in turn utilised this to advantage their position. However, the most constraining aspect of the Scheme was the lack of skilful tact demonstrated in respect to Browne’s engagement with the Catholic Hierarchy. Had Browne been more tactful in addressing the objections of the Hierarchy on 10 October 1950, this might have satisfied them that there was nothing fear in relation to the Scheme and in the process highlight that there was a great deal of support throughout the country for its implementation. Rather, Browne maintained a careless attitude towards the Hierarchy’s objections and believed that the medical profession were the primary opponents to the Mother and Child Scheme (Millar, 2003: 134; Barrington, 1987: 220-21).

Hence, with the acceptance by Costello’s government of the Hierarchy’s authoritative decision, this codified a perception that the Catholic Church was the effective government in Ireland, at least during this decade in the evolution of the Irish State (Barrington, 1987: 221; Whyte, 1980: 249).

4.5.12 The eventual compromise – Health Act, 1953: Codifying the principle of eligibility in the delivery of health care services.

In Fianna Fáil’s return to power, the eventual reforms which came underway proved to be far-reaching and differed greatly from the principles established in 1947. Under the 1953 Bill, it proposed a major extension of entitlements to free hospital care with the Mother and Child principles of the previous act being watered down significantly (Wren, 2003: 39). Thus, Dr James Ryan, in the health Ministry once again, sought not to proceed with the Mother and Child Scheme on its own but rather as part of a wider extension of the health services.
The stimulus behind the enactment of the Health Act, 1953 was the White Paper published in 1952. As such, the White Paper was published to reassure the vested interests of the Catholic Hierarchy that in extending eligibility of entitlement to public hospital services free of charge, this would not pose as a threat to the moral fibre of the Irish population. In codifying this intention, the White Paper stipulated the introduction of three proposed strands of eligibility:

- Lower income group – entitles holder and his dependents to free health services for the duration of the cards validity.
- Middle income group – entitled to hospital and specialist treatment and to new mother, infant and child services and free tuberculosis treatment. This income category would not be entitled to General Practitioner services and had to pay.
- Upper income group – would be entitled to free mother, infant and child services, and in cases of hardship, to hospital and specialist treatment at a reduced cost. They too would be required to pay their family doctors for GP services.

This had the effect of abandoning the principle of a comprehensive and free health services for all children under sixteen years of age and plans to extend general practitioner services to more people (Barrington, 1987: 226).

4.5.13 Objections of the Irish Medical Profession.
In responding to Ryan’s White Paper, the IMA were the first to launch criticism stating that it symbolised a further intrusion of the state in the control of medicine and medical teaching. Additionally, the extensive provision of mother and children medical care proved to be another example of encroachment by the state in welfare provision. The IMA also argued that the extensive social provision outlined in the White Paper proved be conflictual with Catholic social and moral teaching. In contrast to the previous inter-party government, Fianna Fáil did not engage with the medical professions fears. On the contrary, Fianna Fáil were determined to enshrine greater public involvement in the arena of health service provision. The strong stance taken by Ryan in this instance and
limited power of influence held by the medical profession was primarily due to the IMA possessing little if any influence at cabinet level to exploit the decision-making process. Hence, the Minister in contrast to Browne during his tenure, had a strong capacity to implement the proposals outlined in the White Paper (Barrington, 229-30).

4.5.14 Intervention of the Catholic Hierarchy.

Upon circulating the White Paper to the Catholic hierarchy in July 1952, Dr. John Charles McQuaid subsequently summoned Ryan to highlight points which needed to be changed. On meeting the Minster again on the 6 October, McQuaid and members of the commission overseeing this latest proposal on health care reform highlighted a number of objections to the scheme:

- Restatement of concern with the income limit to the mother infant scheme and statement that the bishops could only approve the enactment if a means-test was contained therein. This was thought to be necessitated as a means of complying with Catholic principles.
- Sought protection for persons from any compulsion to utilise the services provided – for instance preventing an occurrence in which a medical officer could detain persons suffering from infectious diseases.

As a result of these meetings Ryan’s response was primarily to make one significant change to his proposals, namely the introduction of an income limit. This pertained that Women in the upper income group who wished to utilise the mother and infant service were required to pay an annual contribution of £1. Additionally, the government inserted in the Bill the safeguard that no individual was compelled to utilise the services provided. Furthermore, the Church was further accommodated by the insertion into the Bill of the power to charge middle income patients nominal charges for hospital maintenance (Barrington, 1987: 230-32).

The medical profession remained to fight hard with the government on the issue of forcing the introduction of contributions or charges for those in the higher echelons who could afford to pay for the mother and infant services. As expected, the Minister did not concede further on the issue and affirmed the government’s position to maintain
the mother and infant service as outlined. This led the IMA publicising that the Bill represented a serious attack on the middle income classes in that its proposals threatened to bring down the standard of the health services and the pauperisation of large sections of the populations. In addition, the IMA sought to redeploy its alliance with the Catholic hierarchy once again to defeat the Bill (Barrington, 1987: 233-34).

As a consequence of the medical profession’s objections, the Catholic Hierarchy’s opposition to the Bill stiffened further. On 17 April 1953, they issued a public statement listing their objections to the Bill which was signed by Cardinal D’Alton of Armagh, the head of the Hierarchy, and was sent to members of the national press and to the Taoiseach twelve hours before publication. Similar to the previous objections, the Hierarchy stated that the Bill – and its extension of eligibility of entitlement – represented an infringement on the rights of individuals and fathers to provide health care for their families (Barrington, 1987: 235).

The objection of the hierarchy came as a surprise to Ryan, as he believed all the challenges had been met; namely the removal of the universal element of the service for mothers and children through the introduction of a nominal contribution for women in the upper echelons in society. As such, the Minister believed the alterations reconciled with Catholic social teaching. Hence, it became apparent to Ryan and his cabinet colleagues that this opposition came to be borne out of the convergence between the medical and ecclesiastical interests. As a consequence of the Hierarchy’s perceived failure to achieve more concessions from Ryan, this meant that a stalemate was swiftly approaching between Church-State relations on the issue (Barrington, 1987: 236). However, in contrast to the previous clash between Church and State, the Hierarchy was attacking the government policy itself and not an individual Minister’s policy.

As an initial move, de Valera and Ryan were in staunch agreement that, having learned lessons from the previous debacle with Noel Browne, a public confrontation must be prevented between the government and the Hierarchy. Additionally both men held a strong conviction that the Hierarchy were being somewhat assuaged by the medical profession in this attack on the Health Bill. In counteracting a crisis emerging, de Valera advised the Hierarchy that if the letter be withdrawn from publication in the newspapers he and his government would resume negotiations with the relevant
episcopal committee. Concessions were made in respect to: increasing the charge for upper-income women availing of the Mother and Child Scheme; a limitation on the power of local authorities to run post-graduate medical schools; restrict the medical inspection of school children to primary schools; and open the public hospitals to clinical teaching by appointees of the university medical schools. Therefore, this assured that the Catholic influence in the public hospitals (Barrington, 1987: 238-41; Wren, 2003: 41). However, when observing closely the outcome of this exchange between the political elite and the vested interests; the concessions/amendments made appeared to be a victory rather than a defeat for government.

In comparing the difference of approach between the inter-party government and Fianna Fáil’s subsequent engagement with health care reform, Barrington alludes to the marked distinction between both administrations in respect to political skill and judgement (1987: 244). This is particularly prominent regarding the distinction in the Ministerial capacity of Dr Noel Browne and Dr James Ryan. In this instance, Browne proved to be inexperienced, made considerable errors in judgements and was crippled by overwhelming opposition from the Catholic Hierarchy, the IMA and his own government colleagues. By stark contrast, Ryan ensured that he had the full support of his Cabinet colleagues, and de Valera in particular as Taoiseach. Furthermore, Ryan demonstrated an astute awareness that the centrepiece to removing the medical profession’s opposition to his health care reforms was to contain the resistance stemming from the Catholic Hierarchy. Thus, having the support of a united Cabinet proved to be a crucial cornerstone in overcoming the challenges posed by the vested interests (Barrington, 1987: 244).

4.5.15 Enactment of the Health Act, 1953 – Impact on the evolution of health care provision.

In summation, the Health Act, 1953 achieved the crux of the Mother and Child Scheme namely; the provision of free post- and ante-natal care for women. However, it left fundamental elements of the system unchanged. For instance GP services were not altered; free medical care for children was limited for infants up to six weeks and treatment in health clinics up to six years. Furthermore, the free hospital and specialist
services that the Department of Health wished to extend to the whole population in 1945 were now only available to those on lower and middle incomes in society. Thus, the principle of *means-testing* came to be enshrined as a method of differentiating classes of patients on the basis of income. Additionally, private practice was sustained in that consultants and GPs had protected their private-fee income. Simultaneously, this also provided an incentive to consultants to devote greater attention to their fee-paying patients (Wren, 2003: 41).

4.5.16 *Summary of key developments during this critical juncture.*

- The conservative ethos which was present in the early days of the newly independent state, stemming from the political elite in tandem with the increasing influence of the Catholic Church on the social policy sphere, had the effect of creating a minimalist form of state intervention (e.g. the principle of subsidiarity definition of a limited scope for the state in social provision).
- Had the Mother and Child Scheme been implemented, this would have represented the first embryonic steps towards the establishment of a universal ‘state medical service’. However, Browne’s idealisms pertaining to socialised medicine were circumvented on three facets: opposition from the Catholic Hierarchy who argued that it was an excessive form of State intervention on the private realm of the family; opposition from the medical profession who regarded the Scheme was a threat to their perceived right to practice private medicine; and opposition from Cabinet colleagues who had clear *informal loyalties* to the social teaching and pronouncements of the Catholic Church.
- With diminishing the possibility of universal access in health service delivery, the Health Act, 1953 codified this process through introducing the concepts of ‘means-testing’ and ‘eligibility of entitlement’ to free hospital services. A policy practice which entrenched further the distinction between ‘public’ (eligible non fee-paying) and ‘private’ (fee-paying) patients in respect to accessing health care provision.
4.6  Critical juncture five – The establishment of Voluntary Health Insurance in 1957.

The developments in the previous juncture surrounding the introduction of ‘means-testing’ and marking a distinction between public and private patients came to be codified further under the critical juncture surrounding the enactment of the Health Act, 1957 – which led to the establishment of Voluntary Health Insurance (VHI). From this standpoint, the establishment of the VHI in 1957 was primarily directed at catering for those patients (in the higher income categories) who were not eligible to retain access to publicly funded health care services. This represented another significant shift away from establishing a state medical service to a process of permanently stamping on the health policy landscape the construct of a public-private mix in health care delivery. The establishment of the VHI, as a critical juncture, is symbolic of being the final piece in the puzzle necessitated in the creation and codification of the public and private sectors as two distinct pillars in the delivery of health care services.

4.6.1 Origins of the Voluntary Health Insurance Scheme: Minister T.F. O’ Higgins concession to the Medical Profession.

The most noteworthy development at this critical juncture was the elevated influence of the Irish Medical Profession in shaping health care reform. The substance of this transition was prevalent in the concessions granted to the medical profession; the most significant of which was the establishment by O’Higgins of a Committee to advise the Minister on the feasibility of introducing a Voluntary Private Health Insurance Scheme (Barrington, 1987: 246; O’Morain, 2007: 178; Hensey, 1988: 186). Under the Health Act, 1953, three categories of people were recognised in respect to entitlement to ‘free’ health care services. Thus, it was the third category consisting of members of the higher income group – accounting for 15 per cent of population during this period – who were ineligible for free health care services that the voluntary private health insurance scheme was primarily targeted (Curry, 2006: 21; O’Morain, 2007: 177-78).

The advisory body that was set up in 1955 consisted of H.B. O’Hanlon as the Chair and its membership included T.C.J. O’Connell representing the interests of the Irish medical profession. Within its terms of reference, the body was tasked with
advising the Minister on the feasibility of introducing a scheme of voluntary insurance that would enable citizens to insure themselves and their dependents in times of need for hospital treatment, dental services or surgical appliances. Additionally, the advisory board also specified that the target group included in the terms of reference were ‘all’ citizens in society and not just those who were ineligible for ‘free’ hospital services (O’Morain, 2007: 178).

In concluding their advice through the publication of their report in 1955, they recommended to the Minister that it was feasible to establish ‘a scheme of voluntary insurance against the cost of hospital maintenance, of surgical and medical services in hospital and of maternity’ (Report of the Advisory Body on Voluntary Health Insurance Scheme, 1956 cited in O’Morain, 2007: 179). However, it also concluded that it was not feasible to include benefits for General Practitioner Services or dental services under the scheme. In terms of organisational structure, the advisory body recommended that the scheme should be administered as a non-profit-making company entity (O’Morain, 2007: 179).

4.6.2 The establishment of Voluntary Health Insurance, 1957: the underlying idealisms influencing its introduction.

Under the Voluntary Health Insurance (VHI) Act, 1957, VHI came into existence and a board was established therein. In terms of the idealisms which influenced the Minister, and by extension the government’s, decision to establish the VHI scheme, O’Higgins explained his thought process in the following manner when introducing the second stage of the VHI Bill in November 1956:

“The aim of such an insurance scheme is to help people to help themselves. This idea of self-reliance is fundamental, and unless the proposal is received on this understanding, it cannot operate successfully. The cost of our present services has such as to tax the resources both of central and local funds, and the time has surely come when further expansion must be along the lines of making it easier for participants to fend for themselves. I hope that it will be possible to create a worthwhile public opinion behind this idea of voluntary health insurance, a public opinion expressive of the determination of our people to preserve our natural dignity as
individuals and at the same time to make prudent provision for the hazards of ill health.” (Dáil Debates, Volume 160, November 7th 1956 cited in O’Morain, 2007: 180).

From this interpretation, it is clear that the Minister’s policy outlook was one which sought to move away from a trajectory course of introducing a state medical service to one that places significant emphasis on the idealisms of: ‘self-reliance’; ‘individual responsibility’ and a lesser form of state intervention. This comes to fruition further in an address given by the Minister at the first meeting of the VHI Board, in February 1957;

“…As to the claim that the State should provide health services for all, I said on more than one occasion while the Bill was going through the Dáil and Senate, that I believed strongly that it would be contrary to our ideals and traditions that the State should supplant individual effort unless there are grounds for believing that the individual himself cannot himself meet his responsibilities. The whole aim of this health insurance scheme is to help people to help themselves; the idea of self-reliance is fundamental to it. Indeed, I take some satisfaction in having sponsored this piece of legislation which enables an important social service to be made available without imposing any burden on the taxpayer or ratepayer.” (cited in O’Morain, 2007: 181).

Furthermore, the emphasis on idealisms such as ‘individualism’ and ‘self-reliance’ was also reflected when the Minister noted that the VHI should not be confined to those who had no entitlement but to also encourage those who possessed such eligibility for free health care services to engage in the health insurance system;

I am convinced that there are many such people who would prefer to cover their health hazards through insurance rather than through the services provided under the Act. Those, for instance, who would prefer to make their own hospital arrangements instead of accepting the arrangements made by the health authorities are likely to be sympathetic to the idea of health insurance. You will have done a good day’s work if you can succeed in attracting into your schemes a number of persons eligible under the Health Act in such a way as to relieve the State and the health authorities of their cost under the Act in respect to those persons. It is significant in Britain, in spite of the existence of the National Health Service, the number of persons taking up voluntary health insurance has grown tremendously over the last few years.” (cited in O’Morain, 2007: 182).
In securing its foundations, O’Higgins advanced the VHI board £13,000 as a means of getting the scheme off the ground. Within a short period of time following its establishment in 1957, the second inter-party government fell and Fianna Fáil returned to government once again where T.F. O’Higgins was succeeded by veteran politician Sean Mac Entee to the Ministry of Health. From the outset, Mac Entee threatened that if the VHI did not become financially independent within the period of a year, he would terminate its operations. However, the new Scheme proved to be a thriving success amongst the upper income group and its continuous growth meant that it had no difficulty in repaying the advancement of £13,000 on the stipulated date. In turn, this led Mac Entee to becoming one of the VHI’s most stalwart supporters during his tenure as Minister (Barrington, 1987: 247).

4.6.3 Assessing the reform attempts during the turbulent years in the politics of health care reform, 1945-1957.

In reflecting on the reform attempts of three doctors during the period 1945-’57; Dr Con Ward, Dr Noel Browne and Dr James Ryan it is attributable that had the momentum of these years and policy vision of the 1940’s been preserved, Ireland might have developed a more egalitarian and universal health service, similar to the systems operating in neighbouring European states. Notwithstanding the significant developments during this period – such as: increased access to free hospital care; improved care for mothers and infants; and the conquering of tuberculosis – the opponents of reform had won a critical battle. As such, health care provision into the future would not be delivered as ‘a right’ or on the ‘basis of need’ but rather it would be subjected to a means testing criteria to determine eligibility of entitlement. On the part of the medical profession, this vested interest successfully resisted state employment from being imposed on the medical sphere. Thus, the profession succeeded in sustaining the distinction between patients who paid for their doctors’ services and those who could not. From the perspective of the Irish patient, the cumulative effect of these reforms in the last two critical junctures ensured that all, but the poorest in society, must pay for treatment from their family doctor (Wren, 2003: 42-43).
4.6.4 Summary of the key developments during this critical juncture.

- The establishment of Voluntary Health Insurance, 1957 elevated the interests of the medical profession in shaping health care reform.

- Through preserving the medical profession’s perceived right to private medical practice and in offsetting the development of a ‘state medical service’; the VHI formally codified the establishment of two distinct classes of patients. Those which are of a ‘public’ status – patients eligible for free health care services – and ‘private’– patients who are ineligible for free health care services and who must purchase health care services.

- The continuous shift away in the health policy trajectory from establishing a ‘state medical service’, symbolised through the introduction of VHI, demonstrates at this critical juncture that the discourse informing policy during this period encouraged the practice of ideological sentiments such as: ‘individual responsibility’ and ‘self-reliance’ amongst patients who were eligible and ineligible for free public health care services.


In characterising the significance of the Health Act, 1970 as a critical juncture, this was demonstrable of a period of great transformation and continuity regarding health service development. In reflecting on this period, Wren (2003: 48) surmises succinctly the central developments to occur;

“Not until the 1970 Health Act did Fianna Fáil again sponsor significant change in the health service – and this was administrative change, rather than improved access, and on terms that suited the profession. The Act replaced the old dispensary system for the poor with the new General Medical Service (GMS) scheme, in which patients could choose their doctor. It established health boards to administrate the health service instead of the local authorities, and Comhairle na nOspidéal to regulate consultant posts, with a majority of consultants among its members. The Act included only one significant extension of eligibility: expenditure on drugs above a certain threshold would be refunded by the health boards, irrespective of income.”

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As a period of significance, it is palpable that the 1960’s and 1970’s epitomised an era of immense change in Irish society both economically and culturally. Within the Irish health policy arena, changes were evident in that there were new medical discoveries (heart disease, cancer and psychiatric conditions) and an increased realisation that the advances in modern medicine could not be made easily available to all patients. Furthermore, the fiscal constraints placed on the system also led to fresh demands for administrative reform (Hensey, 1988: 47-8). In this context, there was a realisation that the Department, rather than Local Authorities, should be vested with the responsibility for administering the Irish health services. To a significant extent, this was in response to a distrust held at Departmental level regarding the capacity of Local Authorities to manage the Irish health services efficiently (Barrington, 1987: 259).

Reform initiatives were also very much present in the Irish Political sphere – being primarily dictated by both the Fine Gael and Labour Parties. In 1959, the Labour Party published proposals for the introduction of a ‘health service for all’ to be financed through central taxation and insurance contributions. While Fine Gael set out proposals for the introduction of a comprehensive health service to be funded largely through insurance contributions for 85% of the population. Additionally, the Fine Gael proposals also contained free choice of doctor and free hospital and specialist services. Thus, the reformist proposals stemmed towards the abolition of the medical cards and the introduction of a universalist/comprehensive form of health service provision. However, under the Ministerial leadership of Sean MacEntee during this period, Fianna Fáil’s policy on health abstained from introducing the comprehensive reform measures proposed by the opposition Parties (Barrington, 1987: 256-57).

Through MacEntee’s establishment of a Select Committee on the Irish Health Services, it became apparent that the status quo on health care reform was not to provide unconditional ‘medical, dental, and ancillary services free of cost for everyone’ but rather the central stimulus was geared towards making more effective use of exchequer resources (Barrington, 1987: 257-58). Therefore, the discourse present in the Irish health
policy arena during this time was one which emphasised on sustaining the system of health care provision established at previous critical junctures.

Hence, what distinguishes this critical junctures from the previous reviewed is that ‘ideology’, ‘cultural norms and values’, ‘philosophical preconceptions’ did not factor in determining the outcome of health care reform in this instance. As Barrington alludes to, between the years 1957-’72 there was an astonishing diffusing of ideological conflict over the nature of state involvement in health service delivery. This was particularly predominant during Mac Entee’s tenure as Minister, as he signalled in his policy outlook a departure away from any ambitions the Fianna Fáil Party may have previously held in respect to providing free health care to the majority of the population (1987: 276).

This modernisation of the Irish health system during this period is particularly prevalent when contextualising the policy blueprint which provided the impetus for the enactment of the Health Act, 1970; White Paper – The Health Services and their Future Development, 1966. Under this report its authors did not go outside the remit established by the Fianna Fáil government – in terms of exploring options associated with a state medical service. The White Paper was commissioned by Mac Entee’s successor Donagh O’Malley and chaired by Brendan Hensey. As such, the white paper recommended the dismantlement of the salaried dispensary system where in its place doctors would receive remuneration by capitation – essentially an annual sum for each of their GMS patients rather than a fee per each visit. However, in objection to this proposal the medical profession lobbied for the ‘fee’ payment system which they successfully achieved under O’Malley’s successor, Sean Flanagan (Wren, 2003: 48).

While socially the dispensary system was not greatly missed due to it being recognised as an institutional relic of the Poor Laws era, it nevertheless represents a loss to the Irish health care systems infrastructure. As Wren states; ‘this salaried local authority service, which might have been used as the basis for a modern state service, had disappeared’ (2003: 48). Despite this, the White Paper made some significant advancements in that it reaffirmed a previous government decision to introduce a ‘choice of doctor’ in the general medical service. Generally, it was perceived that the
introduction of a choice of doctor scheme would improve the services available to eligible patients. As Barrington states;

“The dependence of public patients on one doctor under the dispensary system, irrespective of the doctor’s willingness to give them a good service was a constant irritant. Choosing a doctor from a panel of general practitioners in the area would give a public patient the same kind of hold over the doctor as a private patient. If a patient were being treated badly, he or she could change doctor. At the same time, it would encourage competition between doctors for public patients and provide incentives to the more energetic and able practitioners.” (1987: 254-55).

Most significantly however, it dictated that participatory doctors in the GMS scheme would have to provide the same treatment facilities for both public and private patients and in turn make no distinction between them. Thus, this had the effect of bringing together the former dispensary patients – now holders of GMS medical cards – and private patients into the same doctors’ waiting rooms, which in the process eradicated the discrimination of treatment which previously existed. As such, this represented a process of both enabling social improvement and creating a sense of social harmony between social classes (Wren, 2003: 48; Barrington, 1987: 261-62).

The White Paper also proved to be a forerunner in proposing a radical reform of the administrative structures in Irish health service delivery which it justified on financial grounds. As such, the government envisaged the transferral of administrative responsibility from the existing health authorities to regional boards. Under the health board structure, it was thought that local health authorities would be liberated from the fiscal strain associated with sustaining funds for services through the local rates system – of which at this point was becoming an increasingly unpopular form of local taxation. Furthermore, it was also proposed that the membership of the board would comprise of medical and related professions and Local Authority public representatives (Wren, 2003: 48-49).

A second report commissioned by the government and which proved to be equally influential in the reforming of the Irish health services during this period, was the Consultative Council on the General Hospital Services – better known as the Fitzgerald Report (named after its chairman Professor Patrick Fitzgerald) – published in
1968. The Report recommended the rationalisation of hospital networks, which provoked a hostile reaction in local and health politics. In this regard, it recommended the establishment of a hospital system whereby there would be 4 regional and 12 general hospitals, each with at least 600 and 300 beds within a catchment area with a population at a minimum of 120,000 people. The remaining county hospitals would become community health centres (Wren, 2003: 49).

Hence, the primary objective of Sean Flanagan was to stress that the state’s role in health care intervention should be a minimalist one and that there was no justification for extending health care services to the entire population free of charge. Furthermore, the appetite for radical reform of this nature was also circumvented by other policy issues during this period. The most notable in this context was the rising conflict in Northern Ireland, a policy area which had divided the cabinet and created a major crisis for the government (Barrington, 1987: 252, 264).

4.7.2 Health Act, 1970: its enactment into law.

In the period leading up to the enactment of the Health Act, 1970, Minister Flanagan stressed that the philosophy behind the Bill, which stemmed from the recommendations of the Select Committee in 1962 and re-emphasised that the White Paper in 1966, remained unchanged. Hence, the Minister was not conciliatory towards introducing a policy initiative closely resembling a comprehensive national health service. Rather the prevailing wisdom of the government during this time was to sustain the existing policy towards eligibility of entitlement and concentrate additional resources available to those with real need (Barrington, 1987: 271). Therefore, there was no strong desire to extend eligibility of entitlement for free health care services beyond the poorest income groups in society.

As such, the Bill changed the terminology of eligibility for health services. Thus, the population was to be no longer classified into lower, middle and upper income groups (Barrington, 1987: 271). As Hensey notes, the primary reason for this amendment to the terminology was to essentially codify earlier thinking on eligibility (1988: 63). In this respect, the Health Act, 1970 defined two groups: those with ‘full-eligibility’; and those with ‘limited eligibility’. With regards to the former, full
eligibility was defined as ‘adult persons unable without undue hardship to arrange
general practitioner medical and surgical services for themselves and dependants of such
persons’ (Health Act, 1970 cited in Hensey, 1988: 63). This criterion was thus to
establish whether a person has the ability or not to pay for family doctor services. Apart
from the clarification of the ‘means’ taken into account, this classification is not much
dissimilar from earlier criterions of eligibility established for the dispensary service. In
regards to ‘limited eligibility’, this concerned individuals who without full eligibility
had limited entitlement to public services (Hensey, 1988: 63-64). For instance, persons
with limited eligibility were compensated for costs above a specified amount each
month on drugs. Moreover, patients were also compensated the full costs of drugs
within the remit of certain diseases irrespective of income (Barrington, 1987: 272).

In addition, the election of members to the newly established Comhairle na n-
Ospideal also took place in 1972. The Comhairle turned its attentive focus on the
regionalisation of hospital services by revising the criteria laid down by the Fitzgerald
report. More significantly, the Act also led to the formal recognition of the GMS with a
choice of doctor for patients. On the part of doctors’ remuneration, a ‘fee’ for service
was implemented in 1972 following negotiations between the Department and the
profession on the method of payment (Barrington, 1987: 274-75).

The Health Act, 1970 also codified another significant element which was to
have lasting consequences regarding the entrenchment of the two-tier system of public-
private health service provision. This primarily relates to the Act’s affording of greater
opportunities for Consultants in Health Board hospitals to engage in private practice,
since public hospitals were now beginning to accommodate private and semi-private
patients. Therefore, the Health Act effectively laid the seeds for further discrimination to
occur against the public patient as the medical profession were now in a position to earn
private fees and discriminate in favour of the fee-paying patients in local hospitals
(Wren, 2003: 50).
4.7.3 Defeat of Corish’s attempts to re-introduce socialised medicine to the health policy arena.

In 1969 at a Labour Party conference, the Party restated its health policy initiative to introduce free comprehensive health care service which would effectively absorb the private sector into the public and thus eradicate the two-tier system which was flourishing in the Irish health care system. Upon being appointed as Minister for Health in 1974, Brendan Corish announced a scheme that would provide free hospital care for all. Almost immediately Corish faced opposition from the medical profession. With the Hospital Consultants threat of industrial action, the free access to hospital services plan was defeated as the Minister was unwilling to risk any danger to human life through possible restriction of admission to hospitals that would result from a policy confrontation with the profession. Universal health care was resisted once again and the medical profession’s perceived right to private income was secured (Wren, 2003: 50-51). More significantly, the outcome from this confrontation highlighted that the established system of eligibility of entitlement and the public-private mix in health service delivery was to be sustained as the dominant paradigm in the Irish health policy discourse.

4.7.4 Summary of key developments during this Critical Juncture.

- The enactment of the Health Act, 1970 marked a significant transformation of the Irish health service in that it formally disbanded the dispensary system and in its place established the General Medical Service system. Through providing a ‘choice of doctor’ service in the GMS system, this went some way to reducing the discriminatory distinction between ‘public’ and ‘private’ patients.

- At this juncture, ‘ideological’ or ‘philosophical’ viewpoints on changing the nature of health care provision – i.e. introducing a comprehensive health service – were largely absent. Rather, the primary impetus was to instil ‘efficiency’ in health care delivery. This was realised through the establishment of the regional health board structure.

- ‘Continuity’ proved to be a central theme at this critical juncture in that the philosophical ethos of health care provision remained unchanged. This was
primarily demonstrated through the codification of ‘means-testing’ and ‘eligibility’ of entitlement to free health care services previously established. Therefore, the trajectory of the Irish health care system in moving forward from this critical juncture was one which emphasised on providing free health care for the ‘poorest’ in society and sustaining the private health care market – through health insurance – for those who could afford to pay.

4.8 Critical Juncture Seven – Health Act 2004/establishment of the HSE agency and contemporary issues in Irish health care provision.

When analysing the features that define health care provision in contemporary Ireland some notable correlations can be drawn from the idealisms which oversaw the governance of social provision during the Poor Laws era. This is particularly prevalent when contextualising the operation of the public-private mix and two-tier system of access to health care provision. As such, the Irish government’s utilisation in recent decades of the private health care market as a means-end to the provision of health services demonstrates a political attitude closely resembling the classical liberalist and *laissez-faire* idealisms espoused during the Poor Laws era. This ideological framework elevates the principle of delivering social goods on the basis of ‘ability to pay’ rather than on the grounds of ‘medical need’. Hence, this is symptomatic of the resurrection of societal values from the past such as: *individualism*; and *self-help* which derives a lesser role for the state and a strong onus of responsibility on citizens individually regarding welfare provision.

These idealisms to a significant extent came to resonate with the neo-liberalism orthodoxy adhered to by the Fianna Fáil-Progressive Democrats coalition government which oversaw the establishment of the Health Service Executive (HSE) agency in 2005 and increased incentivising of the private sector in health service delivery (Burke, 2009; Wren, 2003). As such, the existence of the public-private mix, as part of government policy, served to uphold a secure source of funding for the public hospital system and quality service delivery. In theory, this was to occur through facilitating, within the public hospital system, an 80/20 ratio number of beds from public to private patients.
However, as Burke outlines, when analysing percentages pertaining to: patient discharges from acute hospital treatment; planned surgeries conducted in public hospitals; and waiting list figures for public and private patients to receive diagnosis; there is evidence to suggest that the two-tier system favours swift access for private fee-paying patients above that of ‘public’ patients (2009: 13-24).

The existence of the consultants’ contract also serves to reinforce the ‘private sector’ and the ‘market’ in health service delivery. As such, the legislative agreement serves to incentivise consultants to practice privately often in the same public hospital. Furthermore, the existence of the contract has also served to privilege the treatment of private fee-paying patients, in a discriminative manner, above that of public patients who they receive a state salary to treat. Under the current consultant contract negotiated in 2008, under Mary Harney’s as Minister for Health, consultants are now required to work a 37 hour week for a ‘public salary’ to treat public patients. Within this framework, two strands of remuneration exist for consultants who wish to have a ‘public only’ contract and for those that wish to operate in the public sector in parallel with their ‘private practice’ (Burke, 2009: 17-18). The operative practice of the consultant contract in this manner is succinctly described by cardiac surgeon and Blackrock Clinic co-founder Maurice Neligan who expressed that “[y]ou made your money in private practice but you looked after the underprivileged.” (cited in Wren, 2003: 69) Hence, the presence of the ‘private sector’ and ‘market based’ idealisms in social provision has remained to be a continuous trajectory since the Poor Laws era.

The predominance of the private sector and market based policy solutions was also reflected in the introduction of the National Treatment Purchase Fund in 2004. By institutional design, the fund was aimed at providing alternative ‘private sector’ forms of health care in the Irish state or abroad for public patients who found themselves beyond a reasonable length of time on a waiting list (Tussing and Wren, 2006: 81). The significance of this governance initiative is that it reinforced the private sector as an effective medium to meeting the demands of social provision by comparison to the public sector.

During Mary Harney’s tenure as Minister for Health and Charlie McCreevy’s term as Minister for Finance, there was a clear neo-liberal ideologue followed aimed at
privatising aspects of the Irish health care sector. As such, neo-liberalism can be classified as being symptomatic of a rebirth of the classical liberalism principles which favour market based solutions to economic and social issues (Wren, 2003; Burke, 2009). Furthermore, neo-liberalism represents a principle of governance that aims to utilise the private sector as a means of meeting the short-falls of the public sector (see Harvey, 2005). This is demonstrated in particular through McCreevy’s consecutive financial enactments in 2001 and 2002 of ‘tax-breaks’ for the construction of private hospitals. The primary impetus behind this legislative agenda was to establish more private hospitals as a means of freeing up publicly occupied beds by private patients (Wren, 2003: 281-92).

In more recent times, this policy object has been extended further through Mary Harney’s hospital co-location policy initiative. This programme was based on the construction of private hospitals on the same site as a public hospital. The impetus behind this policy initiative was twofold. Firstly, it aimed to facilitate the removal 1,000 beds from the public hospital system within its first five years of functioning. Secondly, it was primarily designed to facilitate consultants to sustain their private practice in conjunction with their obligations under the public hospital system (Burke, 2009: 199-207). Hence, as Mary Harney described, the co-location policy programme aimed;

“…[to] pull together in a concerted and focused way the different strands of government policy in relation to Health Strategy commitments, tax breaks under Finance acts, private insurance and economic charging. It will ensure greater capacity for public patients, at all the same time, a more vibrant and innovative role for the private sector.” (cited in Burke 2009: 200)

4.9 Conclusion
From the historical institutionalist theoretical precept of the critical juncture, this chapter reviewed crucial moments in the Irish health care system’s evolution which inevitably shaped the contemporary structure of access and governance in health service delivery.

This chapter has chronicled how ‘universal’ principles of access have been consistently rejected in successive health care reforms. Instead, the policy residues stemming of the
Poor Laws era has been found to have a significant impact on the character of social policy development. The policy precepts of ‘deserving’ and ‘undeserving’ poor in particular have proven to be significant in shaping modern policy constructs regarding ‘eligibility of entitlement’ and ‘means-testing’ as a determinant to accessing free publicly funded health care services. Furthermore, the associated Poor Laws ideological sentiments of: ‘individualism’; ‘self-help’; ‘non-state intervention’; and the ‘upholding of the free market’ in social provision have also been dominant in shaping successive health care reforms. As such, this comes to be reflected in the: establishment of the health insurance market; the public-private mix; and the continuous incentivising of the private sector in the delivery of health care services. Hence, the principle of delivering health care services according to ‘ability to pay’ rather than on the ‘basis of medical need’ has featured as a central theme in this chronicle of health care reforms.

The implications of the critical junctures findings in the context of equality, efficiency, and institutionalism theory will be discussed further in Chapters Six and Seven in relation to the interview findings and the research questions of this study. In the next chapter, the interview findings from this study will be presented.
Chapter Five

Interview Findings: perspectives of political, administrative and academic actors in the health policy domain.

5.1 Introduction
As part of this research, interviews were conducted with a sample of participants with expertise and knowledge of Irish health care policy and the concept of social provision generally. Those interviewed were selected from three disciplines which impact on the development of Irish health care policy. In total, twenty-two interviews were conducted with participants ranging from the Irish political sphere – past Ministers and Public Representatives; Policy Advisors; Administrative officials – from the Civil Service and Health Service Executive Agency; and in the field of academia – Health Policy Analysts/Commentators.

The interviews with participants sought their views on a range of topics relating to perceptions on: equality – in theory and practice in health service provision; the evolution of the Irish health care system and the influence of the vested interests which shaped that process; and efficiency – in the administration and governance of the Irish health services. The interview findings presented in this chapter primarily relate to objectives one and two of this study which relate to the concepts of equality and efficiency in service provision.

5.2 Linking the ‘past’ with the ‘present’: the parallels of the critical junctures and empirical data findings.
In the previous chapter, the historical trajectory of the Irish health care system’s development was explored. As such, the secondary data collection placed significant emphasis on the cultural norms and political idealisms which have overtime shaped and dominated the policy structures in respect to access and entitlement in health service provision. Furthermore, the critical junctures in this context illuminated how consecutive health care reforms have continued, since the Poor Laws period, to embed and reproduce a mixed-motives system of libertarian and egalitarian principles in the
structures of health service delivery. In many respects, the final critical juncture reviewed in this study surrounding the Health Act, 2004/establishment of the HSE agency and contemporary issues in health care provision epitomises further a policy trajectory of successive health care reforms which has continued to invoke the policy principles of ‘individualism’ and ‘self-help’ through the private market. This is in parallel to an egalitarian premise which, through the policy instruments of ‘eligibility of entitlement’ and ‘means-testing’, have sought to provide public health care provision to those in the lower income strataums and the most vulnerable in society. Thus, the contemporary policymaking environment of health care provision is reflective of the finished product derived from a path-dependent policy course which has adhered to the principle of delivering health care on the basis of ability to pay rather than on the grounds of medical need. In particular, this is reflected in the wider policy practices which have evolved overtime such as the application of the public-private mix and two-tier access in government policy.

The secondary data collection in this sense has provided a coherent historical chronicle of how the features which characterise health service delivery in modern times has been sustained in the Irish policymaking environment. In extending this analysis further, the primary data collection seeks to explore, empirically, the policy ideals which structure the policymaking environment in contemporary times. While an historical element is imparted in the primary data, this chapter broadens the critical junctures analysis more specifically through exploring how the policy ideals which have been sustained overtime are interpreted and applied in practice from the perspective of stakeholders in the policymaking environment of Irish health care. Thus, the interview data extends the analysis of the latter crucial junctures reviewed in this study (Health Act, 1970 and Health Act, 2004/establishment of the HSE agency) in that it seeks to illuminate further, in theory and practice, policy conceptualisations surrounding equality of access/entitlement and efficiency principles in the governance structures of health service delivery. Moreover, the secondary data findings is expanded further through the empirical data’s acute focus on the ‘policy outcomes’ that derive in practice from the overarching principled frameworks which dictate the scope of health care provision in egalitarian (i.e. access and entitlement) and efficiency (i.e. administrative governance)
terms. In this regard, there is also an explicit focus placed on the policy outcomes produced in terms of practices where equality-efficiency and inequality-inefficiency are evident in service delivery.

From this standpoint, the secondary data analysis in tandem with the primary data collection facilitate a core linkage between the historical and path-dependent trajectory of the Irish health care systems development with the issues or themes which dominate the contemporary health care system in terms of access and entitlement. This is also evident in respect to exploring the principles of efficiency in terms of the governance and administrative practices associated with health service delivery.

5.3 Perceptions of core stakeholders in the Irish Health Policymaking arena: Categorisation of Interview Participants.

In this study, twenty-two qualitative semi-structured were conducted with a range of core stakeholders in the Irish health policymaking domin. As stated previously in chapter 1, section 1.5.2, the diversity in the professional backgrounds of interview participants was to enable the incorporation of a broad range of perspectives pertaining to core concepts and policy practices pertinent to this study’s overarching research questions and research aims and objectives. All interview participants were granted anonymity and were referenced in the presentation of interview findings according to their assigned interview participant number (e.g. IP, 5). The following is a categorisation of the interview participants and their function/role as stakeholders in the Irish health policymaking domain:

- **Political Actors** – Public Representatives – past and present; Former Ministers for Health; Opposition Spokespersons for Health.
- **Administrative Actors** – Secretary Generals and Assistant Secretary Generals in Department of Health (past and present) and National and Regional Directors in the Health Service Executive Agency.
- **Policy Advisors** – Policy Advisors to consecutive Ministers for Health and Political Parties.
- **Academic Commentators** – **Health Policy Analysts** – Academics (Health & Social Policy Academics; Egalitarian Theorists and Welfare State Theorists);
Health Policy Analysts (Political & Policy Commentators; and Vested Interests in the health policy domain).

Notwithstanding the standardised interview schedule utilised in each interview, (see Appendix I), the data collected have provided some enriched insights from the distinctive perspectives of each sphere of stakeholders in Irish health policy. In Appendix II, a table is provided which categorises the interview participants and their function/role in the Irish health policy domain. In addition, the table details an overview of the data collected from each of the four interview participant categories.

5.4 Thematic analysis of qualitative interview data: utilising NVivo 10 computer software and the data analysis process.

In analysing the primary data collected, this study utilised NVivo 10 (as stated previously in chapter 1, section 1.5.3) as a means of managing the data and in the process create transparency regarding the method of deriving the data findings. While it rests with the researcher to conduct the primary data analysis, the NVivo computer software analysis nonetheless facilitated a succinct audit of the transcripts. Following the importation of the interview transcripts into NVivo, a process of categorising the core themes to emerge from the interview transcripts was undertaken. This was enabled through NVivo’s inbuilt Open Coding system. Figure 5.1 below provides a sample of the Open Coding System applied in this study.
The subsequent and final phase of this process consisted of an analysis of the data and generated themes. This primarily involved the fusing of the core themes/findings pertinent to the overarching research objectives of this study and also the reduction of irrelevant data. Below, in Table 5.1, the strategic approach utilised in the management of and process of data analysis is outlined.
Table 5.1 – Strategic Approach to Primary Data Analysis.

<table>
<thead>
<tr>
<th>Data Analysis process</th>
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<tbody>
<tr>
<td><strong>Phase One:</strong></td>
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<tr>
<td>- Import transcripts into the data management software – NVivo 10.</td>
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<tr>
<td><strong>Phase Two:</strong></td>
</tr>
<tr>
<td>- Categorisation of interview nodes/themes.</td>
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<tr>
<td>- Open Coding of interview transcripts and development of core themes.</td>
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<tr>
<td><strong>Phase Three:</strong></td>
</tr>
<tr>
<td>- Content Analysis of nodes/generated themes</td>
</tr>
<tr>
<td>- Engagement in a process of data reduction – facilitating the illumination of the relevant data.</td>
</tr>
<tr>
<td>- Synthesising of the primary data findings and generated themes.</td>
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5.4.1 Categorisation of primary data findings and generation of core research themes: process of Open Coding within NVivo 10 computer software analysis.

As stated from the outset in chapter 1, section 1.5.2, the interview schedule (see Appendix I) devised for the qualitative semi-structured interviews was classified into three distinct sections. In the first section, the discussion topics centred on participants’ perceptions on equality in philosophical terms. In addition, the first section sought to explore how consecutive health care reforms have addressed the concept of equality in theory and in practice. The second section of the interview schedule explored the participants’ observations on the principles of ‘efficiency’ which influence the governance structures overseeing health service delivery in recent decades and also in terms of the policy outcomes produced. In the final section of the interview schedule, the discussion points centred on participants’ observations on concepts such as the welfare state model and social provision in both an evolutionary and contemporary context.

From this standpoint, the categorisation of the research themes/nodes to a significant extent corresponds with the sections of the interview guide. In Table 5.2 below, the nodes/research themes developed within NVivo following a succinct review
of the interview transcripts are outlined. As such, the Open Codes are categorised into four distinct sections.

In the first categorisation of nodes, participants’ perceptions on equality in theory and in policy practice are recorded. As such, the data recorded reflect interview participants’ philosophical understanding of equality in terms of the competing perspectives in egalitarian theory (i.e. Equality of Opportunity, Equality of Outcome and Equality of Condition) and also the perceived overarching policy objectives/guiding policy principles in health care provision. Furthermore, the nodes catalogued themes surrounding the distinctions in theory and practice between ‘equality’ and ‘equity’. Additionally, the nodes also catalogued the interview participants’ perceptions on prevailing features of both ‘equality’ and ‘inequality’ evident in the structures of the Irish health care system. The nodes also recorded participants’ understanding of the historical milestones in the development of the Irish health care system. There was also an emphasis on the Health Act, 1970 and Health Act, 2004 in the process of characterising the existence of equality in the structures of health service delivery.

The second category of nodes contains data themes surrounding the principles of ‘efficiency’ and ‘administrative governance’ in health service delivery. In this regard, there was a particular focus on recording participant observations surrounding core issues and impetuses surrounding the establishment of the Health Boards following the Health Act, 1970 and the Health Service Executive Agency following the Health Act, 2004. The nodes in this sense reflect the core issues/themes which have influenced the development, both in theory and in practice, of ‘efficiency’ and ‘administrative governance’ principles in Irish health service delivery. In contemporary times, the nodes additionally recorded the interview participants’ observations on service delivery in terms of the efficient and inefficient policy practices which have emerged following the establishment of the HSE Agency in 2005. This category of open coding also catalogued perceptions on the balance which is attributed to both concepts of ‘equality’ and ‘efficiency’ in terms of which poses as a dominant principle dictating health service delivery and the policy outcomes of Irish health care policy. In this context, the nodes within this category also recorded the interview participants’ observations on issues of equality and inequality evident in policy practices during the HSE era.
In the third category of open coding, the catalogue of nodes relate to the primary data themes which stems from the interview participants’ observations on idealisms pertaining to the concept of social provision and the welfare state model in an evolutionary context. In this regard, the nodes recorded the core values of the welfare state model highlighted by interview participants in contemporary times and observations on the future direction of social provision. For instance, core themes/issues such as the perceived increasing role of the voluntary-community sector and a lesser role for the state in social provision were recorded. The final category primarily relates to generic themes or issues catalogued pertaining to the structures and policy practices of Irish health service delivery in modern times.

While the nodes catalogued are significant in the wider policy context of Irish health care, the engagement in a process of content analysis and data reduction nonetheless highlighted that not all were deemed pertinent to this study. In this regard, the solidifying of the primary data findings was facilitated further through a process of synthesising the core themes to emerge from the analysis process with that of the overarching research questions and the research aims and objectives of the study.
Table 5.2 *Categorisation of the core Research Themes/Nodes derived from the primary data findings.*

<table>
<thead>
<tr>
<th>NVivo 10 Computer Software Analysis – Research Themes/Nodes derived from primary data findings.</th>
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<tbody>
<tr>
<td>Category One:</td>
</tr>
<tr>
<td><strong>Participant perceptions on equality in theory and practice.</strong></td>
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<tr>
<td>• Definition of Equality.</td>
</tr>
<tr>
<td>• Definition of Equity.</td>
</tr>
<tr>
<td>• Distinction between Equality and Equity - positive and negatives - struggle about what each term means.</td>
</tr>
<tr>
<td>• Characterisation of Equality in the context of the Irish Health care system.</td>
</tr>
<tr>
<td>• Characterisation of existing inequalities in the Irish health care system.</td>
</tr>
<tr>
<td>• Periods which reflect great significance in the development of the Irish health service.</td>
</tr>
<tr>
<td>• Contextualising the 1970 Health Act in terms of Equality.</td>
</tr>
<tr>
<td>• Contextualising the 2004 Health Act in terms of Equality.</td>
</tr>
<tr>
<td>• Guiding principles which aid policymakers in the drafting of Irish health care policy - in the context of health care system models and equality.</td>
</tr>
<tr>
<td>Category Two:</td>
</tr>
<tr>
<td><strong>Efficiency Principles and Administrative Governance in the Irish health care system.</strong></td>
</tr>
<tr>
<td>• Impetus for policy actors when enacting the Health Act of 1970.</td>
</tr>
<tr>
<td>• Central issues or concerns which led to the establishment of the Health Service Executive Agency formally in 2005.</td>
</tr>
<tr>
<td>• Evidence of efficiency in the Irish Health Care system since the establishment of the HSE.</td>
</tr>
<tr>
<td>• Evidence of Inefficiency in the Irish health care system since the establishment of the HSE.</td>
</tr>
<tr>
<td>• Evidence of greater equality in the Irish health care system since the establishment of the HSE.</td>
</tr>
<tr>
<td>• Evidence of inequality in the Irish health care system since the establishment of the HSE.</td>
</tr>
</tbody>
</table>
### Category Three:

**Participant reflections on the concept of social provision and sustaining the welfare state model.**

- Views and perceptions on the welfare state and the role of the state in social provision.
- Characterisation of the evolution of the welfare state in a modern context.
- References to the Government's decision to introduce Universal Health Insurance.

### Category Four:

**General primary data themes.**

- Evidence of Discursive Institutionalism and Discourse themes.
- Evidence of Historical Institutionalism.
- Evidence of Sociological Institutionalism.
- Development of Primary Care - its significance.
- References to the Nursing Homes Subvention Scheme.
- Positive Campaigners in health care – consultants.
- Having a strong Public Hospital System effectively advances equality - Cancer Strategy as a primary example.
- Argument for devolving responsibility of health services to local or regional authorities again – reference to the Ireland being the same geographical size of Manchester.
- Co-Location positives and negatives.
- Reference to Consultants Salary – and its proportionality.
- Failure to rationalise hospitals in Ireland as a problem.
- Deficiencies of the system: there was never an effective Houses of the Oireachtas Committee on Health.
- Role of vested patient interest groups in promoting equality.

### 5.5 Theoretical perceptions on the concept of equality.

Participants offered a variety of interpretations on equality as a theoretical and practice concept. In particular, there was a broad consensus on the complexity associated with conceptualising equality and how it manifests in a wide range of domains within the social policy arena. Within a philosophical context, it was observed that there were four broad theoretical schools of egalitarianism prevalent when assessing the concept of equality and the meanings contained therein.
These are as follows;

- Equality of Distribution and Non-discrimination;
- Equality of Opportunity;
- The principle of Equity;
- Equality of Outcome;
- Equality of Condition.

Hence, the interview findings centred on how the above theoretical variants operate in practice – particularly relating to equality of access issues in health care provision. In this context, a vast majority of interview participants favoured an egalitarian premise which would oversee a health care system governed according to the principle of access being granted on the basis of *medical need* rather than *ability to pay*. However, when characterising health care provision in egalitarian terms, the general consensus of participants was that the system, in its current standing, adheres to a theoretical principle of equality of opportunity. This was observed by some interviewees to act as a barrier in gaining access to health care provision in a *universal* manner. Effectively, this informed a belief amongst participants that the Irish health care system should be modelled according to an egalitarian premise of equality of outcome, which is depicted as a more encompassing precept of equality. As such, this idealism is believed to not only incorporate an individual’s right to equality of access to health care provision. On the contrary, it delves into much wider dimensions in health care, such as facilitating equality in health care status across all socio-economic income groups in society.

At a rudimentary level, equality has been defined by interview participants as pertaining to a notion of achieving ‘sameness’ in society. This reflects an egalitarian vision in which people are paid the same financial increments for the same type of employment specification, are treated the same regardless of their upbringing or ‘social class’ in society and where in general terms citizens are regarded to have equal worth and value in societal terms (IP, 8). Therefore, an individual’s social and economic background should not act as a barrier to his/her progression or functioning in society. This conceptualisation of ‘sameness’ and ‘freedom from discrimination’ reflects an
idealism of achieving distributional equality in society. As stated by other interview participants, this area of egalitarian focus directs attention to a ‘gap’ which is thought to exist between the ‘better off’ in society and the ‘least well off’ and the imperativeness of attending to that as a core issue in social policy. In many respects, this relates to a widely-held perception of a correlation that exists between high levels of inequality and corresponding detrimental consequences for outcomes in areas of crime, health status and quality of life in a generic sense. The quote below surmises the significance of addressing the issues above as an initial starting point to the achievement of equality;

“…basic civil liberties in the sense of equality before the law and equality in terms of civil and political rights in terms of voting and so on and so forth. And basically freedom from discrimination or discrimination in regards to those rights. When it comes to the question therefore on top of that I suppose [it] is the question of equality in regards to economic standing or social position or social standing.” (IP,13).

Within this general conceptualisation, equality symbolises a process of preventing the discrimination of individuals in the social and economic spheres. This is representative of a process which encourages distributional equality and a sense of ‘sameness’ and ‘freedom from discrimination’ in society. Thus, the perceived goal of social policy is to eradicate inequality through reducing the gap between the ‘better off’ and ‘least well off’ in society. In health care, this translates into delivering health care services according to the principle of ‘medical need’ rather than ‘ability to pay’.

5.5.1 Competing perspectives of equality in determining access to health care.
In a generic sense, equality has come to be defined in terms of there being distinctive gradients where from one end of the spectrum there being equality of opportunity (which reflects a limited form of egalitarianism) to ensuring more extensive forms of greater equality (i.e. equality of outcome or condition). In the context of equality of opportunity, it has been described by some participants as providing, in a general sense, ‘equal chances’ for individuals in accessing vital social services which can affect one’s life chances, such as education and health care. This pertained to a vision that aimed to
create structures and conditions in the event of there being inequality of opportunity for people through discriminative barriers.

According to interview participants who adhered to this egalitarian school of thought, equality of opportunity is upheld as a framework most appropriate to addressing the current and existing woes in social policy. This is set in contrast to the theoretical precepts of equality of outcome which is argued to be simplistic in its objective towards the achievement of sameness of outcome. The following quotation explains this egalitarian premise of equality of opportunity within both a theoretical and empirical contextualisation. It is essentially asserted that each individual is distinctive as a human being. This is based on a perceived notion that we are not born equal due to the fact that we have unique characteristics such as drive, ambition and being a member of a particular social class. Therefore, due to the fact that by nature we are born unequal, equality of opportunity as a principle is regarded as the most proficient methodologically to facilitate the ‘balancing out’ of existing inequalities in society and in the process grants each individual a fair chance in life.

“…you could say equality means everybody should be equal, but we’re not. And my sense is that we’re all born with different talents, different make up, different metabolisms which effect things like drive, ambition, energy. So we are not all born equal actually in some respects. By definition we are not and there is the issue of equal before the law, equal as citizens in terms of right to vote and the very fundamental rights, rights of equality and liberty that we should all enjoy irrespective of race, creed, colour or disability. There is class; there is [in]equality in terms of social-economic class in terms of what one is born into. So by definition if you are born into an area where there is significant economic disadvantages, significantly more challenges to climb and stemming from that then I think in policy terms, I would be favouring the concept of equality of opportunity to balance out things so that a person gets a fair chance in life.”(IP, 9).

When analysing the perceptions of participants to the egalitarian premise of equality of outcome, it was perceived as both an alternative viewpoint and critique to the premise of equality of opportunity. The findings highlight that the principle of equality of opportunity, as a singular theoretical approach, does not proficiently ensure that inequality can be substantially eradicated in society. This stems from a belief that it cannot be exercised to the fullest extent by people when they do not have sufficient
resources (i.e. income, wealth) in the first instance. As one interview participant points out, in reality the position of equality of opportunity is not sustainable in guaranteeing that equality is delivered to the highest extent possible.

“If you have the income you can get access to the service, if you don’t have income a lot of the time you have to wait. But if you take a situation at the moment that a person who hasn’t a medical [card] which doesn’t mean they have high income at all. That person may have a GP visit card, so the person can go to the GP and be told that you need this medicine or treatment or whatever, but they don’t have the money to buy it and they don’t have access to a free scheme or a discounted scheme in any case, in any [form]. So therefore they can’t access it, so that’s a very serious inequality in terms of access so we have an “opportunity” to get something but you can’t get it, so it’s nonsense. They can’t get it because they don’t have the money to buy it…” (IP, 4).

The theory of ‘equality of condition’ also bears similarities to the previously interpreted egalitarian concept of equality of outcome. Under this principle, participants again provided a critique of equality of opportunity and its flaws as a theoretical construct to providing a lasting sense of equality in Irish society. In the quotation below, it is demonstrated that while ‘opportunity’ is available to grant people the best chance in life, the egalitarian ethos becomes redundant due to the continued existence of a perceived hierarchy of wealth, income and power. This entails that inequality remains to exacerbate the social and political landscape.

“[E]quality of condition means that people have effectively the same opportunities in life as others and it means that you address unfair advantage. So it focuses on what actual opportunities people have and what you know they can achieve rather than what you hypothetically think … [you] might achieve. Probably the best way to describe it is that it is different from (a) liberal view of equality of opportunity which is fundamentally [where] liberal[s] believe that there is a hierarchy in society. [W]hat you do is for example you help women to get into the position men are in or you help poor people to get into more advantaged positions but you don’t alter the hierarchy of wealth, income, power, status or care that you’d leave the traditional gender division of labour, you’d leave the hierarchy of power.”(IP, 2).

From an historical and empirical perspective, participants have observed that equality can be articulated from a range of differing perspectives. It has been articulated
that the health service initially was designed to cater for minority groups, such as granting traveller and homeless people access to health care. This vision of equality was thought to incorporate social inclusion generally through aspects such as ‘drug treatment services’ as part of an overall equality based service (IP, 21). Therefore, at a foundational level, health care provision came to represent equal access to health services based on medical need rather than on the premise of ability to pay or ones social position in society. This assertion is developed in the following quote, which documents that while medicine remains to be the greatest development in the twentieth century, its increasing demands in fiscal terms has meant that intervention was required to reduce the gap between those who could and could not afford medical care.

“..I think it was one of the greatest developments of the twentieth century was the notion of providing [health care]. As medicine became increasingly expensive and also increasingly effective because, it could actually do a lot more for people, it did become an awful lot more expensive. There was a growing gap between those that could afford medical treatment and those that couldn’t and there was this great movement at the beginning of the 1930’s … to make sure that people regardless of income could access medical care and medical treatment (IP, 3).

In a modern context however, the discourse on what defined ‘access’ to health care provision underwent a transition in the sense that policy actors no longer speak of a health care system with access to care on the basis of medical need. Conversely, the discourse or policy paradigm which emerges is one which encapsulates the premise that no one will be denied access to care on the basis of their ability to pay. As the following quote explains, due to the demands for access to health care services increasing at a rapid pace, this had the ultimate effect of institutionalising concepts such as the ‘waiting list’ in the Irish health care system.

“… in one sense it sounds the same but it’s actually a subtle difference and the fact that that became embedded it meant as the queues [and] the pressure on the hospitals system for access became greater, the fact that the policy was that nobody will be denied access on the basis that they can’t pay meant that it wasn’t incompatible with the notion some people would have to wait longer for access because they couldn’t pay enough either cash or be covered through insurance.
So you had a tolerance of inequitable waiting lists and even a refusal to count [or] even to try and measure what was going on in the system” (IP, 3).

Each competing egalitarian perspective differs in its approach to addressing inequality. From the outset, ‘equality of opportunity’ seeks to ‘balance out’ existing inequalities in society and thus enable individuals an opportunity to pursue a ‘fair chance’ in life. However, it is critiqued that this theoretical perspective cannot ensure a lasting sense of equality in society. The perspective of ‘equality of outcome’ highlights that while individuals may possess ‘opportunity’ through access to social goods, such as education and health care, this form of equality becomes redundant due to the ‘outcome’ being to a large extent determined by an individuals’ availability of resources (i.e. income). While ‘equality of condition’ theorists argue that inequality will always surface due to the ‘equality of opportunity’ principle sustaining the hierarchal system of wealth, income and power in society. Hence, this highlights that ability to pay rather than the principle of medical need is a defining characteristic under this framework. This is exemplified in a practical sense whereby it was observed that the increasing demands being placed on the system (i.e. evolution of medical technology), institutionalised the principle of ‘ability to pay’ in the system as a financing mechanism.

5.5.2 Distinguishing between the concepts of ‘equality’ and ‘equity’: instilling a spirit of fairness in health care provision.

In a modern context, it has been highlighted that as the Irish health care system evolved, it no longer lends itself to an outright egalitarian principle of access. This is marked through deriving the concept of equity of access to health care provision. As the interview data highlights, both conceptual terms, ‘equality’ and ‘equity’, have significant consequences in terms of what constitutes access to the Irish health care system. At a basic level, one interview participant defined equality as getting ‘what you need’ whereas equity pertains to getting ‘what you deserve’ (IP, 1).

Essentially, this distinction has proven to have significant ramifications in terms of the outcomes of policy in the health care arena. As one policy actor noted, equality denotes a theoretical approach which aims to distribute equally the resources produced
in society between social groups and/or individuals. This interpretation contrasts greatly to the concept of equity which aims to institute ‘fairness’ in respect to the allocation of resources. Hence, attaining the goals of equality of outcome in terms of health status and equality of access on the basis of ‘medical need’ rather than ‘ability to pay’ becomes subsided under the theoretical guise of ‘equity’.

“The tendency I think in Irish social policy has to be far more concerned with equity than equality. Equality as I understand it, and I would make a clear distinction between it and equity. Equality I see as a state of being equal or a distribution of resources or availability of resources equally between groups or between individuals. I would see equity as a state of judgement, admittedly a subjective one of what constitutes fairness. So my starting point before even trying to look at the central tenets of social policy in terms of equality would be to distinguish between those two and I think in Irish healthcare policy our focus has tended to be on what is fair, in other words what is equitable …” (IP, 19).

This endorsement of ‘equity’ in Irish health care policy effectively embeds the policy constructs of ‘means testing’ and the ‘GMS medical card’ further in health care provision. As the quote below describes, the existence of the medical card instills principles of equity and fairness through ensuring that the lower socio-economic income groups who ‘cannot’ afford to pay are in the position to avail of primary care services for free. Whilst the means-testing criterion ensures that those who ‘can’ afford to pay continue to do so. Thus, the principle of ability to pay within the public/private mix remains to be a predominant pillar in the terrain of Irish health policy.

“… our concern has always been what is fair and what is reasonable and the tenet of Irish health policy has been whatever else the rest of the population, the higher income groups have, try and make sure that the lowest income groups have some minimum standard. And that essentially for good or bad is what we have been doing. What can we do for the lowest income groups ie those most likely to be on medical cards, what’s (the) at least minimum level of provision that we can offer them. I think there has been far less attention to equality as I have defined it i.e. equal access between groups and equal availability of services between groups. On the assumption that we are not going to give the same level of free health care to somebody on €200, 000 versus somebody on €5,000.” (IP, 19).
As such, the achievement of absolute equality in the context of both access to health care provision and the assurance of equalised health status outcomes does not feature as a primary concern amongst policy actors. This is premised on a belief that people will always be willing to pay for swift access to a perceived higher level of health care access than those who cannot afford to pay for health care services. Thus, outright equality is not regarded as a feasible objective on the part of policy actors. Instead, as a former policy actor explains in the quote below, the concepts of safety and quality in health service delivery hold a more prominent position in the articulation of policy.

“… I think this notion of equality for the people; I don’t think any government ever set out to achieve that. … [Y]ou are going to have income differences anyway; nobody is setting out to remove those … We don’t actively set out to provide for example what’s available [in] top notch health insurance plans to everybody who gets on the medical card, that would be an equality… We simply couldn’t do that because people will always pay for the gold standard or whatever it is. Simply because they have established income. … But we do set out to provide the safest standard of care for everybody; [to concentrate on] what is the normal burden of health issues that you [accumulate] over a lifetime. [Thus] the principle of policy we always talk about [is that] the same opportunities will be available to people whether they are insured or not. The reality has been that in a supply constrained system … we would never manage to provide the same standard … that equality of care. …” (IP, 20).

From this interpretation, access to healthcare provision is not provided in an ‘outright’ manner but rather on the basis of ‘fairness’, in terms of ensuring that lower income groups in society, through potential discriminative structures, would not be inhibited from receiving basic health care provision. In turn, this embeds the public/private mix in the Irish health care system whereby the ideal of ability to pay supersedes the principle of access to hospital treatment on the basis of medical need.

The disparity which exists between the concepts of ‘equality’ and ‘equity’ in health care provision also resonates with what one former public representative describes as the lack of a definitive framework of equality in the system. As such, it is depicted in the quote below that an ‘inbuilt’ or ‘internal’ form of equality exists within the respective boundaries of particular income groups. Hence, it is perceived that there
is a lack of a ‘national’ conceptualisation of equality that is inclusive rather than exclusive of particular income groups in society.

“You see my problem is that it’s difficult to define any strong elements of equality within the system. Undoubtedly there is equality for the very lower income group of medical card holders. There’s equality within the groups. VHI people have inbuilt equality within that framework, exclusive framework and then medical card holders have an internal level of equality which is a very open question of elements of equality I mean undoubtedly they have equality on access to drugs. … [W]hen we come to hospital care it’s totally varied, totally open to access depending on the particular medical condition. …The short answer is that there isn’t any built in form of equality certainly no national form of equality within the health system… If you are on a certain income category you have certain entitlements. If you are not you don’t have.” (IP, 11).

From the above interpretations, it is observed that the policy discourse has demonstrated a strong tendency to focus on equity as oppose to equality in health service delivery. The focal point in this regard has been to institute a ‘spirit of fairness’ rather than an outright egalitarian ethos in the provision of health care. This is exemplified through the existence of the GMS medical card whereby it is perceived to be ‘fair’ that the lower socio economic groups in society receive access to free health care while the upper income groups continue to fend for themselves. However, this framework sustains inequality amongst income groups, as the idea of ‘ability to pay’ rather than the principle of ‘medical need’ remains to be a dominant feature on the Irish health policy terrain (exemplified through the public-private mix and two tier access). In part, this resonates with a belief that no national or universal egalitarian framework exists in dictating the governance of health care provision.

5.5.3 Equality of Outcome in service provision: instilling equality through ensuring efficiency and quality in health care delivery.

The ideal of there being no definitive egalitarian stance in the health policy arena, becomes more prevalent when assessing the report published in 2001, *Quality and Fairness: A health service for you*, which detailed issues pertaining to equality and efficiency in the Irish health care system. In theory, this report represented a significant modernisation of the Irish health service into the 21st century. As one participant
observed, the report for the first time in the development of the health services represented a genuine ‘patient centeredness’ approach to the initiation of health policy in Ireland (IP, 7).

While the primary focus of the report was on fairness and access issues, it also emphasised on factors pertaining to ‘equality of outcome’. As the quotation below describes, policy actors at the time believed that gaining access to the health care system proved to be futile if the desired health outcomes were unachievable. Therefore, the primary impetus was not on delivering outright equality in service provision. On the contrary, this report, within an efficiency context, aimed to advance the ‘quality’ of treatment available to the Irish populace. As such, the focus on quality was part of the process in tackling the three major health care concerns of the time; heart disease, cancer and accidents.

“…I was involved in the health strategy of 2001 and what was exercising our minds hugely then, [was] not just fairness and equality of access issues, but also equality of outcome issues. So [for] the quality issue, there is no point in having access to a health system if you are not getting the outcomes that one requires. So equality of outcome is very important, that actually and equality of treatment …[W]e had three big killers in Ireland ultimately heart disease, cancer and accidents… So looking at it from a population [health] approach, … we had a cardiovascular health strategy which has been very successful. We’ve transformed the heart healthcare in Ireland and [w]e had [the] cancer care strategy… I still think there is probably equality of treatment and equality of outcome, I think equality of access has still some distance to go” (IP, 9).

In delving further into this understanding of equality, it is perceived that the concept only exists at the level of rhetoric. As the following quote describes, the policy documents published by successive governments offer no clear and concise definition of equality or indeed equity for policy actors to follow in the initiation or implementation of health policy. Consequentially, this is perceived to have led to an inequity developing in the system largely because there is no clear philosophical position within the institutional framework as to what equal treatment for equal need ascertains to be.

“Only at the level of rhetoric, I mean if you read the health strategy in 2001 you would have [noticed] one of the things they would talk about would be equity and fairness. … But there has
[been] quite a deal of confusion as to what’s meant by equity. … we have … ended up with a very inequitable situation because of, largely because we haven’t confronted that issue. [W]hat we’ve been trying to do is make it explicit what we mean by equal treatment for equal need and grounding that in your values, in your political culture…” (IP, 18).

Despite the lack of definition pertaining to equality, some participants in the policy sphere view the concept of ‘equity’ as a positive force in positing a spirit of fairness in the delivery of health care provision. As the following quote explains, one of the primary concerns of policy actors, including those who articulated the health strategy in 2001, is to ensure that those who have particular health conditions or in lower income categories, are afforded health care while those who can fend for themselves continue to do so.

“…[E]quality of care needs and medical needs and how do you decide those things … is the reason why in the health strategy people talk about equity of access. That is, [is] it equitable that some care group or some group of people get more than others. …[Y]ou have for example a cardiovascular health strategy, is that about equality? It’s equitable that more focus and attention should be paid to that than [higher income groups] because you say well you know other people are well able to take care of themselves and do so. So with spending public money and focusing on a particular group, [it] is equitable. Spending money on you know [on] the breast cancer screening for women is seen as equitable. Well you could say well that offends against equality, well it does but so what it is equitable.”(IP, 13).

In modern times the primary focus has centred on developing a ‘patient centred approach’ and a ‘quality’ and ‘efficiency driven’ health service. In this regard, it is highlighted that the primary emphasis is not on the provision of an outright vision of equality. On the contrary, the focal point is on elevating patient outcomes through improved efficiencies and quality treatment. Furthermore, in contemporary public policy there remains to be an ambiguity surrounding the meaning of equality as a guiding principle. As such, it appears that the framework is governed on the premise of instilling ‘equity’ and ‘fairness’ in the system. For instance, the cardiovascular strategy is characterised in this context as not being resourced as a measure to ensure equality but rather to provide an essence of ‘equity’ and ‘fairness’ in the system.
5.5.4 ‘Paternalistic’ and ‘Outright’ conceptions of Equality: a practice of taking care of the ‘needy’.

The interview findings have also highlighted what one public representative described as a ‘paternalistic’ vision of equality prevalent in the system. Historically, this depicts a perspective whereby government policy in a generic sense, engage in a process of ‘taking care of the needy’ and their basic needs rather than achieving outright equality across all social income groups in society. Therefore, the focal point is to ensure that the basic needs of patients are catered for irrespective of income or health condition.

“Well there was a kind of a paternalistic … attitude … you know that we look after the needy. … [I]t wasn’t about them being equal … in society. It was more about we’ll look after their basic needs. So it wasn’t really an equality approach, it was more like the paternalistic … social wing of the St. Vincent de Paul, … it was around you know caring for the needy type of thing. [T]hat was the kind of approach you know it wasn’t around modern thinking on equality which is around mutual respect and equal rights and you know equality of treatment and all that. So it was a different perception of how the State should care for people who maybe haven’t the ability to financially care for themselves.” (IP, 12).

Since the 1970’s, an academic commentator in the quote below depicts that there has been a shift in the policy making arena regarding the achievement of equality. As such, it is perceived that there has been a notional shift from the object of achieving outright equality to the aim of reducing or eradicating prevailing poverty in society. Hence, it is ascertained that a significant distinction exists in the outcomes of a policy directive that seeks to eradicate inequality in society to one which aims to remove poverty.

“…[I]t seems to me that social policy has been marked by a move away say over the last twenty five years. Certainly since the 1970’s in Ireland and I think this would be mirrored if you examined policy documents in other countries internationally. But certainly in Ireland it has done so and it’s even moved away by at least a national objective of creating greater equality I think towards an emphasis upon when one talks about distributional issues an emphasis upon poverty and I think the shift is a very significant shift and the significance of it is missed by most observers and indeed by most policymakers. But poverty and inequality while linked are two very
distinct concepts and social policy I think has lost focus upon trying to reduce inequality and has replaced it with a focus on trying to reduce poverty.” (IP, 6).

In assessing this argumentative point empirically, this same academic commentator describes in the following quotation that policy directives in this manner demonstrate how the concern with inequality in a distributional context has been replaced with an ideal which seeks to prevent discrimination against minority groups in society and in the process reduce poverty. Furthermore, it is apparent from the social policy and legislative directives, such as the anti-poverty strategies and indeed the establishment of the Combat Poverty Agency58, that the intent of policy actors in the preceding three decades has been firmly directed towards the objective ideals of preventing discrimination and the reduction of poverty rather than eradicating prevailing inequalities in Irish society. As such, it is interpreted that the philosophical backdrop of a legislative act or policy directive, within an egalitarian context, can hold a significant bearing on the outcome and the contribution which social policy brings to improving or advancing ones life-chances and functionality in society.

 “[A] focus much more on poverty and the issue of equality came to be focused in much more on issues of discrimination or trying to ensure against discrimination against minorities. So inequality moved away from being a distributional concept, to be a concept that had to do with recognition of minorities and the distributional concept that came to the fore in public policymaking was the issue of poverty. But one can have a focus on reducing poverty in a society where inequality is increasing and in fact that’s what indeed happened in Ireland after all we had our anti-poverty…the combat poverty agency and all that and the National Anti-Poverty Strategy of 1997 etc. all of those were noteworthy but as I pointed out at the time it was very noteworthy to me that inequality didn’t factor as an objective, reducing inequality. The focus was exclusively on poverty and one as I say can have declining poverty in a society with increasing inequality.” (IP, 6).

58 Combat Poverty Agency established in 1986 with three specific functions pertaining to issues of poverty; policy advice, project support and innovation, research and public education. In 2009, the agency was dissolved and its functions are now undertaken by the social inclusion division in the Department of Social Protection (Combat Poverty Agency, 2014).
From this contextualisation, it characterised that the focal point in respect to equality has shifted from the aim of achieving distributional equality in society to a social policy position which aims to eradicate poverty. In health care terms, this reflects a paternalistic vision whereby the object is to take care of those ‘in most need’ rather than develop a universal framework of health care entitlement.

5.6 Characterising the existence of ‘equality’ in Irish health care provision.

When characterising empirically the existence of equality in the Irish health care system, it is interpreted that an outright vision of equality does not predominantly feature in the system. Nonetheless, it has been denoted that a ‘basic’ form of equality features within the institutional structure of the Irish health care system.

In this context, the GMS medical card and the universal public nursing for new mothers, both of which are present in the primary care sector, reflect an aim to achieve equality in the Irish health care system. In the following quote, the GMS medical card is symbolised as a measure aimed at ensuring that those in the lower socio-economic income groups in society receive health care provision. Hence, in the decades preceding the Health Act, 1970, the GMS policy articulated focused on introducing measures which encompassed an element of ‘purposeful equality’. This term is indicative of an emphasis being placed on the lower socio-economic groups in society. As such, this highlights that equality is not objectified in a universal context.

“I think some aspects of the system, like the medical card or like universal public health nursing for new mothers and small children, have a strong equity or equality dimension. … So I think there are elements of promoting equality or equity within the Irish health care system which are purposeful. I think they are done on purpose particularly the 1970 Health Act…I think the medical card, like the work by the ESRI has shown, the medical card is a pro-poor measure. … It does work for people on lower incomes in that say you can go to your GP without having to pay and up till very recently you got your prescription drugs for free” (IP, 5).

59The Economic and Social Research Institute, through its research activities, provides analysis and evidence based research to facilitate informed policymaking (ESRI, 2014).
It is clear that the ethos now is perceived to be on elevating equality through the advancement of health services provided within quality and efficiency terms. As such, the *Quality and Fairness – A health system for you*, 2001 report is reflective of a policy agenda not solely focused on issues pertaining to equality of access to health care provision. On the contrary, it was perceived that the scope of health care provision needed to be widened to encompass issues pertaining to the ‘quality’ of health services provided. At a practical level, this is believed to be the primary ethos behind the reinforcement of public health care institutions, above the private health care sector, with the necessary resources in terms of multi-disciplinary facilities (e.g. centres of excellence). Equality in this sense is characterised from an ‘equality of outcome’ based approach rather than ‘equality of opportunity’ precept whereby the focus would be solely pertaining to *accessing* health care services (IP, 9).

Therefore, it is suggested that in the decades following the year 2000, the discursive paradigm governing health care provision came to be dominated with the aim of providing a strong infrastructural network within the public hospital system rather than having disaggregated units of public and private hospitals delivering services in a parallel form. As a political actor closely involved with the drafting of the health strategy notes, this formed part of a desire to achieve a ‘population health’ approach in health care provision. Hence, it is believed that the system has evolved to a point where equality exists through achieving positive patient outcomes and in advancing the health status of the Irish citizenry.

“I think in 1970, that the idea of equality was equality of access and treatment. I think it is more refined in 2004 because I think it’s more about the issues I talked about, it’s not just access it’s equality to quality treatments and outcomes. It’s no longer just about you get to see a doctor you know you get to see the right doctor and the establishment of HIQA\(^6\) for example that I was involved in was very much about driving a standards based approach to health. Now I am very strong on that because I think everyone is on about access and access is vital but there is no point in giving people access to a very poor system you know. That’s something I think you know, the two are connected.” (IP, 9).

\(^6\) Health Information and Quality Authority established in 2007 with the primary role of promoting quality and safety in the provision of health and personal social services for the benefit of the health and welfare of the public (HIQA, 2014).
When characterising the existence of equality in the system, it is apparent in an evolutionary sense, that the focal point has been on delivering a ‘purposeful’ or a ‘pro-poor’ vision of equality whereby the primary emphasis has been on providing access to health care for the lower-socio economic classes rather than on the development of a universal system of health care provision. In contemporary times, emphasis has shifted further away from solely providing equality of access towards a policy focus on developing a ‘population health’ and a ‘standards driven approach’ to health care delivery.

5.7 Characterising the existence of ‘inequality’ in Irish health care provision.

The Irish health care system encompasses what has been depicted as strong empirical evidence of inequality within its institutional structures. This proves to be all the more encumbering when reflecting on the issue of access to health care provision.

In historical terms, the characterisation of existing inequalities – e.g. the ‘public/private mix’, ‘two-tier access’ and ‘queue jumping’ – within the Irish health care system’s institutional structures extends far beyond the contemporary context. As such, it is perceived that the residues of the Poor Laws period entrenched a divisive and somewhat discriminative echelon between the poorer and wealthier socio-economic classes in Irish society. As described in the quote below, while access to primary care is reflected as a positive feature for those in receipt of a GMS medical card, it is in the domain of secondary care and access to public hospitals where the Poor Law concepts of deserving and undeserving poor comes to fruition. Hence, the ‘public/private mix’ and ‘two-tier’ access elements in modern times are presented as being inherited from the Poor Laws period.

“… [I]t’s in a way a continuation of the Poor Law …it’s like a poor service for the poor people rather than a good service for everybody. … [N]ot explicitly, but implicitly it’s like the deserving and undeserving poor… and the undeserving poor get this free access. The really big problem with it is that even if you have a medical card, if you are poor or without health insurance in Ireland or without ability to pay you have slower access to the public hospital system and that’s where for me the real inequality exists between who can get diagnosis specialist treatment and
hospital care when they need it and the absolute reality is that if you can pay to see a consultant privately or if you have private health insurance you can get into even the public hospital system not just the private hospital system quicker.” (IP, 5).

The characterisation of inequality has also been attributed to the label of being a ‘public patient’ which in itself has been described as leading to further discrimination for the poorer socio-economic income groups. As an academic commentator describes in the following quote, this process comes to be reflected in the experiences of patients’, public and/or private in status, when accessing the Irish health care system. As such, it is believed that being labelled a public patient has an inbuilt connotation of access being constrained with respect to public health care services. Hence, the practices associated with ‘access’ is perceived to be a fundamental source of inequality within the Irish health care system.

“[Two patients with] cartilage out of place, key hole surgery needed, quality of life seriously impaired both walking around on crutches, both very limited in what they can do… One as it could be VHI, and already has an appointment for key hole surgery in the sports clinic in Santry at the hands of the leading orthopaedic surgeon in the country, took three weeks to set up and three weeks is long because he is very busy. The other has no health insurance and [will] never ever get access to him. May ultimately get access to an orthopaedic surgeon in Finglas, in Vincent’s or somewhere, but God only knows when. But the pain is the same, the only equality is the pain.” (IP, 1).

The existence of the public-private mix and discriminative elements in terms of access has been described as being rooted in the policy practice of ‘eligibility’. As such, the policy instrument of eligibility is perceived to correlate with the ideal of ‘entitlement’ to health care provision which institutionalises the demarcation lines further between the status of patients into the categories of public and private. As the excerpt below denotes, the continuance of the policy instrument of ‘eligibility’ reinforces the principle of ‘ability to pay’ rather than ‘medical need’ in accessing health service provision. Therefore, it is articulated that equality cannot co-exist with an operating policy instrument which seeks to differentiate patients in accordance with their stated level of income and resources.
“[A]n equal health service makes all patients equal and the only thing that differentiates patients in a fully equal health service is their medical need. That is the only thing that differentiates patients. We do not differentiate between patients on that basis. We differentiate patients on the basis of income and resources, not on the basis of medical need. So, and they have been the guiding principles. I mean that differentiation has been a guiding principle from the moment eligibility was established, there has never been equality.” (IP, 1).

The adverse effects of this differentiation can be amply demonstrated, as one former policy advisor asserts, when assessing the position of the ‘coping classes’ in society. The ‘coping classes’ comprise of those patients who are not eligible under the entitlement criterion for a GMS medical card and who have not got sufficient income or resources to purchase health insurance in the private sector. In this context, a perception exists in which ‘eligibility’ criterions serve at best to indent more inequality in the Irish health care system for both the lower and middle income socio-economic classes.

“I think that between those who have medical cards and those who would have private health insurance there is a huge gap of people out there, a massive gap. There are people whose incomes don’t allow them to qualify for a medical card but that are what everybody calls the coping classes and they are people and I know them and you know them and everybody knows them who now think twice about going to a doctor because of the costs of it and I think there is very real inequality there.” (IP, 15).

The central crux behind the acceptance of the current structural dynamics of health care provision appears to be a cultural phenomenon exclusive to Ireland. The cultural element to this acceptance of the public-private mix rests on a phenomenon that those who make a financial contribution deserve to gain swifter access to such provision. This is distinct from the models of health care services provided by our European counterparts whereby patient access to health care provision is on the basis of medical need rather than ability to pay.

…[I]n some ways I think there is a cultural thing in Ireland as well that has … that if you can pay more than, it’s okay that you get better access to service. Whereas in the British model there is … a kind of commitment to National health that developed way back after the war. … I suppose
what I would have wanted to do when I was working in this policy area was to kind of replicate the systems in other countries … whereby you got access on the basis of need and everybody was in the same kind of queues and the same kind of waiting systems… [E]ssentially what developed in Ireland was … an unequal system but also a system that wasn’t efficient because you had this kind of parallel layers of administration for different categories of patient.” (IP, 12).

In terms of identifying the central reasons for creating a dualist system in an historical context, one academic commentator argues that as the Irish health care system evolved and as new advanced medical technologies emerged, health care provision came to be increasingly capital intensive. This encouraged policy actors to look towards the private sector and engage in the process of market incentivising as an ample solution to facilitating a secure line of funding (IP, 3).

Within this contextualisation, it is believed that the Irish citizenry – particularly those in the middle to upper income categories – came to be encouraged and/or incentivised to utilise the private sector through availing of private health insurance as a means of meeting their respective health care needs. As such, this is believed to have formally entrenched the demarcation lines between those patients that were to be referred to as ‘public’ and ‘private’ within the two-tiered structure that it evolved to become.

“Amazing advances in medical care, all of the sudden the demand for health care grew, the supply of medical care did not expand at the same pace and critically incentives were put in place that encouraged both doctors and patients to go private, go for private care. So all of the sudden, instead of the middle classes having incentive to ensure that the public hospitals to system grew in order to meet their needs, the middle classes who by and large are the people who are insured privately were given the incentive to bypass the public system …[E]ven though most of that private care was in the public system. So … they were jumping the queue [and]… over the heads of people who didn’t have private health insurance to get faster access to the public resources.” (IP, 3).

In terms of finding a solution to the present issue of inequality of access, one former policy advisor provided a policy recommendation which would eradicate discrimination between public and private patients. As the following quote explains, in order to maintain the current system of public and private practice, there needs to be a
legislative ‘health status act’ to deal with the issue of discrimination of public patients in favour of private patients. The idea of establishing a health status act represents a stepping stone to bridging the discriminative gap between public and private patients. Thus, rather than instilling an outright egalitarian ethos, the core objective is to ensure that when citizens opt to utilise public facilities, no discrimination shall occur which would indelibly favour the interests of the private patient above that of the public patient.

“… [W]ere we the state funded we are going to insist that there is no possibility of discrimination and that’s what my proposal would have done, would do. And, you can say in the context overall, it would be [an] incremental reinforcement, incremental development on the ensurance to the citizen of [a] basic level about equality in regards to hospital service. … Rather than going for a big bang and to say every health service in the country is provided on the same basis to everybody … irrespective of anyone’s ability to go to a doctor themselves if they want to pay them out of their own pocket. … In my own perspective I think I don’t have any issue with people paying co-payments to doctors.” (IP, 13).

Within this conceptualisation of inequality, it is contended that the institutionalised practices of: two-tier access; public-private mix; and eligibility of entitlement are residues from the Poor Laws era and its associated policy differentials of deserving and undeserving poor. In particular, it is highlighted that the policy idea of ‘eligibility of entitlement’ is the primary source of inequality in contemporary health care provision. This is founded on the premise that it acts as a barrier to the introduction of an egalitarian framework of universal entitlement. In the process, it also reinforces further the principle of delivering health care on the basis of ability to pay rather than medical need. Furthermore, the current inequalities which characterise the Irish health care system also thought to resonate with a cultural element in society which endorses the ‘public-private mix’ and the idea of gaining swift access to services on the basis of financial contribution. Therefore, due to the system incentivising private health insurance and swift access on this basis, it is believed that policy needs to focus now on eradicating discriminative gap between public and private patient access to health care provision.
5.8 Irish health care system in an evolutionary context: perceptions on periods of significance and the power of vested interests.

When analysing the development of the Irish health care system, as the following quotation depicts, the establishment of the dispensary system was symbolic of laying the initial baseline of public health service provision to the Irish population. As such, it invariably shaped the institutional fabric of the Irish health care system in the modern context.

“…I would actually go back to the old dispensary system and the whole public health agenda, you know in the 1940’s, ‘50’s, ‘60’s. Like the real carnal of health care is public health and the baseline health of the citizen. It’s not neurosurgery you know … there was a very good syetem in the old, this is pre-1970 where you had your dispensary doctor and your nurse and every kind of crossroads had one and they did a huge amount of really good work that was sort of the bedrock of modern services and I think we sometimes have lost sight of that.” (IP, 22)

As noted by a health policy commentator, the dispensary system also engraved an enduring legacy in the institutional structures of the Irish health care system. This is particularly relevant in respect to the policy instruments of ‘eligibility’ and ‘entitlement’. As such, the legislative wording of the 1858 act, in effect led to the demarcation of patients into the status of public and/or private, which originated from the concepts of ‘deserving’ and ‘undeserving’ poor during the Poor Laws era. Additionally, this came to be institutionalised further in the succession of acts which followed.

“[T]he old dispensary scheme whereby people could apply initially to one of their poor law guardians for a medical card and that would allow them to a free episode of treatment by a doctor. That developed into the medical card system as we know it with the original tickets being replaced by a card.... But... the old poor law wording is still actually in use. In order to demonstrate your entitlement to a medical card you have to show that without undue hardship you cannot look after the medical needs of yourself and your dependents. So …you had to be the deserving poor before you could receive help. … [T]he fact that legislation governing access to primary care is still based on the 1850’s … in the 1970 health act seems to me an extraordinary carry over that no government, has felt strongly enough about equitable access to medical care to change that legislation” (IP, 3).
Hence, the dispensary system proved to be not only an infrastructural milestone in the development of the Irish health services, but also in terms of its significance in continuing the Poor Law principles of deserving and undeserving poor.

5.8.1 The dominance of vested interests in the evolutionary process.

During particular stages in this evolutionary process, it is believed that resistance rather than acceptance proved to be a central theme in respect to health care reform. In particular, it is perceived that the National Health Insurance Act, 1911 and the Mother and Child Scheme, 1948 established a precedent which the state would not adopt a ‘dominant’ role in the provision of health care according to the principle of medical need. Furthermore, as the quote below depicts, the role of vested interest groups, specifically the Catholic Church and the Irish medical profession, and their resistance to state interference proved to be significant in shaping health care reform.

“...We’ve resisted that right from 1911 onwards and we certainly missed out on the whole concept of the welfare state after the Second World War and we had the same with the Mother and Child episode and so on. So it really shows and you can see very clearly the forces that were at work to avoid having a system where people would get health care on the basis of need and to protect the vested interests … [T]he vested interests of the Church who didn’t feel that the state had [a] role in a domain like health and certainly not the dominant role and … then the doctors so on to protect their income. …Whereas in most countries you would maximise access to primary care and deal with the need for the best, the most appropriate level which is primary care.”(IP, 18).

It is prevalent that when self-assessing the periods of significance in the development of the Irish health services, the Mother and Child Scheme proved to be of endemic importance amongst the majority of interview participants. As such, the Mother and Child Scheme for many participants symbolised the reaching of a crossroads in which the state is encountered with a decision to provide health care provision in accordance with the principle of universality or, as had occurred, going down the route of a two-tier public/private mix in health care provision.

At a foundational level, the establishment of a de facto Department of Health was depicted as a revolutionary cornerstone in the Irish health care systems
development. This is based on the belief that it evolved to become a crucial
development in facilitating a point of access for key stakeholders involved in health care
provision, such as the Catholic and medical interests. Thus, the establishment of the
Department provided a public arena through which contextual debates and discussions
surrounding health care provision could take place. Furthermore, as a former public
representative notes, it demonstrated the significance of external cultural institutions,
such as the Catholic Church in shaping the trajectory of health care provision.

“...[W]ithout a doubt the setting up of the Department of Health was a key period ... [L]ike the
Department of Education, it was dominated by Knight of Columbanus in the higher echelons of
the Department of Health and it was watched with huge concern, watched by the Catholic
[stalwarts], notably John Charles who had his emissaries within the Department. They saw the
new Department being set up but they were very determined to find out exactly what was going
on inside in it and there was the development, the on-going development of the public and
voluntary hospitals and the Catholic Church had control of the Public Voluntary Hospitals. ...”
(IP, 11).

The Mother and Child Scheme was perceived to hold a significant position in
setting the scope of health service development in the decades which followed. As the
following quote describes, it established the key stakeholders which came to shape its
development. Furthermore, it is perceived that due to the dominance of the Catholic
Church and the Irish medical profession during this debacle, the conservative orthodoxy
prevailing in Ireland superseded any desire by politicians such as Noel Browne to
introduce socialised medicine as a consequence.

“...the Mother and Child debate around the Noel Browne era which was a very seminal time in
Irish history insofar as like even the idea of just providing care for mother and baby before and
after birth was such a challenging concept for Irish society where the Church and Doctors ganged
up basically on the state and the state backed down. So I suppose it shows that the concept of
social medicine, the concept of the state taking responsibility rather than the family solely having
responsibility for the health of the family, that was a really important time as well. But it was a
time when the debate lost, I suppose you know, it was lost to the more conservative elements of
Irish society at the time. (IP, 12).
From the above interpretations, it is prevalent that the role of vested interest groups has been depicted as hugely significant. This is particularly relevant when participants disclosed their observations on the periods which witnessed the establishment of the Department of Health and debacle surrounding the Mother and Child Scheme. As such, the access points granted to the vested interests onto the institutional stage of policy formation paralleled with the respective roles of the Catholic Church and the Irish medical profession is believed to have been paramount in shaping the course of the Irish health care policy into the future.

5.8.2 Influence of the Catholic Church in the evolution of the Irish health care system.

When analysing the role of the Catholic Church as a key stakeholder during this period, participants provided diverse perspectives on the position held by the Church regarding social provision. From an ideological viewpoint, a former public representative notes that the central rationale for the Church’s extreme hesitance towards state intervention in health care and social provision rests on its strict adherence to the principle of ‘subsidiarity’. As an ideological concept, it was perceived to have left an enduring mark on the institutional fabric of social provision in Ireland from the 1940’s period up until the latter part of the 1970’s decade.

“The Church believed in one extraordinary principle, the principle of subsidiarity. … In other words that anybody who could afford to pay from their own health insurance [and] health care … should be obliged to do it … and the state should only come into the equation provided the person was destitute or semi-destitute and it was then the obligation of the state to pick up the pieces or make basic provision. So effectively the Catholic Church in Ireland right up till the … late 1970’s were totally opposed to the principle of universality of services, totally opposed because they were of the view that this would encourage people not to look after themselves so to speak and would encourage the state to step in and do things for people what they should be doing for themselves and the state should have no great role.” (IP, 11).

When positing the dominance and influence of the Irish medical profession in shaping the development of the Irish health care system, some participants concluded that the dominance of this professional group’s vested interests became, as one health
policy analyst observed, “...[more] influential in alliance with the Catholic Church in the 1950’s, ‘40’s and 50’s.” (IP, 14). This is particularly pertinent when analysing how both the Catholic Church and the Irish Medical Profession during the Mother and Child Scheme were staunchly opposed to the development of publicly funded health care.

As an academic commentator notes, while the Catholic Church’s dominance in modern society has dwindled somewhat in recent decades into a social democratic predisposition, its role and predominance in the earlier decades played a crucial role in facilitating the rise of private interests in health care provision. This was perceived to be most notable in its facilitating, albeit not intentionally, the permanent fixture of private health care in Ireland.

“Now since the 1960’s of course the Catholic Church’s position has changed and it has come to favour much stronger state involvement interestingly I mean the Church in its sort of principled stance on social policy in general has become much more what one would label I think as social democratic. The Irish state hasn’t been very much influenced by that aspect of the Church’s changing principled stance. But of course the Church, while it might adopt in various statements in public policy which issues from time to time those sorts of principles, in practice it has defended strongly its institutional interests and that defence has tended I think to play into the hands let’s say of private interests. I don’t think it was designed necessarily to favour a stronger private health care system.” (IP, 6).

The rise of private practice also originates from the significant role played by the Church in the infrastructural development and concurrent patronage of voluntary/private hospitals throughout the country. As such, it is believed that the dominance of the Catholic Church in previous decades led the prevention of substantive egalitarian measures being introduced in the health care arena. This is described in the quote below through reference to the example of Brendan Corish’s defeated attempts, during his tenure as Minister for Health, to introduce reform. Hence, the Church’s dominant influence in the arena of social provision at earlier decades facilitated a climate to develop in which vested interests could thrive.

“[I]n practice I think … it has resulted in … [being] unable to adapt a comprehensive policy towards the development of the health care system. I’m reminded of Brendan Corish when he
was Minister for Health, now Brendan Corish was no great radical, but he did identify the Church and the medical profession as fundamental obstacles if I remember rightly to the achievement of rather modest policies that he had to develop a more equitable system. So I suppose what I am getting at really is that the Church created [for] decades a climate…in which vested interests have thrived and have been very dominant in ensuring that state policy has favoured them and state policy has been very weak in trying to fashion an overall plan for a more equitable health care system.” (IP, 6).

The failure to develop a comprehensive state policy with respect to health care provision also originates from the ‘peripheral’ role which the state adopted in the early stages of the health care system’s development. Furthermore, as an academic commentator notes the bureaucratisation of health care in Ireland which occurred in the latter half of the twentieth century meant that as the system evolved it came to be immersed in grappling inequality. As such, it is believed that the capital intensive nature of the system and issues of funding played a significant role in fabricating a system which has ‘grown up’ to support private sector initiatives as a means of *meeting the gap* in health care funding. This is believed to have significantly led to the growth of inequality in tandem with the desire of the state to cope with the increasing capital intensity borne out of the expansion health care technologies.

“[W]e have evolved from a very paternalistic system run by and large by the Churches, particularly the Catholic Church, where the state had a relatively peripheral role within it certainly in terms of issues to do with equality of access etc. …[M]y impression is that inequality has grown in the system … due to issues of funding [looming] much more larger than they did in the past and as that has happened the state policy has worked … by default to some extent and by design in other ways I think to allow a system to grow up where people who can afford private access gain greater benefits as a result of that, particularly in terms of speed of access. Now that has to do with the way in which I think to some extent following cut backs in the late 1980’s… [I]t is a system characterised by a lot of crisis points … and state policy seems to have been unable to deal with these [and] … overcome the growing inequality that seems to be built into the system. [This is a] … result of state policy I think because state policy has just … sought really to push more people into reliance on private health insurance.” (IP, 6).
The failure to develop a ‘comprehensive’ and ‘egalitarian’ health service in the Irish case has been interpreted as a response to the power of the Catholic Church and its associated idealisms. In particular, the concept of ‘subsidiarity’ is perceived to have been significant in limiting the role of the State in health care provision. Hence, the influence of the Catholic Church in the arena of social policy has been interpreted as facilitating the development of a fertile ground for idealisms such as private practice to flourish. Due to the initial peripheral role adapted by the state in this area and the raising costs associated with arising medical technologies, this escalated the incentivising of the private sector in health care delivery. In turn, inequality became inbuilt in the system.

5.8.3 The Irish Medical Profession’s influence in the evolution of the Irish health care system.

The Irish medical profession has been regarded by various participants as being hugely influential in the course of designing and shaping the institutional fabric of the Irish health care system. As one health policy analyst describes, the persistence of the current system of two-tier access to health care is largely afforded to the instrumental manner in which the medical profession preserved private practice in Ireland. Thus, the Irish medical profession is believed to hold significant bartering power with regards to facilitating and/or preventing developments in the Irish health care system (IP, 5).

As a policy actor notes, the influence of Irish medical profession is apparent when observing the significant power dynamics which exist within the medical/administrative-politico spheres. This is particularly relevant when considering the significance of having the medical profession ‘on board’ when attempting to successfully introducing legislative changes in health care provision.

“[U]p until 1970 and since then all of the major developments they have either been shaped by, influenced by or opposed by the medical profession to put it bluntly. ... If you haven’t got them on board things have been blocked. For example the 1991 extension of eligibility was something that came close to being blocked by the medical profession because they were afraid of losing private practice. ... [U]p till 1991 about 15 per cent were liable for consultants’ costs. ... They said hold on a minute we have no guaranteed people coming to us anymore. We pointed out at the time that ... 15 per cent of the people at the moment has to pay you privately but 30 per cent of
the population is privately insured in VHI … in fact since then the proportion of the population covered by private health insurance rose to over 50 per cent, it’s gone down a bit since…” (IP, 19).

The existence of this power dynamic between the medical profession and the political elite is perceived to be the result of a close relationship which exists between various political parties both ‘in’ and ‘out’ of government. As a policy advisor notes, the close alliance with the political organisations coupled together with their *insider* knowledge of the Irish health care system has positioned this professional group as a dominant force when it comes to the bartering table discussions on the future direction of Irish health policy.

“They are a very politically shrewd group. They are very well qualified medically obviously and the best medics in the world are up there in the top twenty. But they are extremely influential politically with all political parties and they use that to their own advantage. There is no doubt about that and within the health system in particular they would be the dominant group and they would be the least open to change unless it suited them.” (IP, 16).

Thus, the modern features of inequality (i.e. two-tier access and the public-private mix) which we associate with contemporary health service delivery are believed to resonate with the influence possessed by the medical profession in shaping the institutional fabric of the system. In particular, it is highlighted that the significant ‘bartering power’ held by the medical profession in the Irish health policy arena was effectively utilised to preserve private practice in service provision.

**5.8.4 Source of the Irish medical professions power in modern times: the Consultants Contract.**

In sourcing the influence of the medical profession in modern times, a number of participants have cited the existence of the ‘Consultant’s Contract’ as a *case in point.*

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61 The consultant contract is the product of a negotiation process between government and the Irish medical profession in the provision of state salaried positions for consultants within the public hospital system. The contract negotiations since it first emerged during Charles Haughey’s tenure as Minister for Health in the 1970’s has proven to be controversial aspect in Irish health care provision. This rests on the premise that it permits consultants in tandem with their salaried public hospital duties the right to an unlimited private practice. As a consequence, the existence of the consultant contract effectively
As an academic commentator notes, during the course of the Irish health care systems evolution, the Irish state granted the medical profession privileges that were distinctive by international comparison. The primary dispensation granted to the medical profession lies in the sustaining of private practice in health service provision. In turn, the relaying of power of such magnitude has led to a perception of state sponsorship in support of the dualist system – the public/private mix – and institutionalisation of inequality in the system.

“Well I mean a major milestone I think was the deal that Haughey did with the consultants back in the early 90’s …[w]here consultants really were given a most astonishing set of privileges. I mean first of all to be employed on what by international standards are very high public salaries but then side by side with that to be able to carry out private practice in public facilities. This is astonishing, I don’t know of any country where anything similar to that exists and of course that introduces a fundamental issue of inequality, and it’s a state funded inequality. I mean here the state is actively encouraging this dual system and the ability of consultants to see private patients while they’re working in public posts. … So that to me is a fundamental milestone towards ever greater inequality.”(IP, 6)

Thus, the contract is believed to act as a barrier to the introduction of more egalitarian measures and indeed efficiencies in health care provision. As a policy advisor notes, the influence of the Irish medical profession can be observed in the intricacies associated with the consultant contract negotiation process between the political and medical spheres. As such, the medical profession is depicted as being somewhat of a ‘gatekeeper’ to facilitating change from taking place in health service provision. Furthermore, it is also perceived that incumbent ministers are hesitant to challenge the medical profession on issues aiming to alter how health care is delivered and the increments received by medical personnel.

“[M]y experience was in the decade of the noughties or in particular 2004 to 2010 but also in the three years beforehand. … [I]f the state wanted to, in looking at contract revisions from 2004 onwards, … to create a contract which just had public … care within public hospitals and any

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consolidated the two-tier system of preferential access for private patients in public hospitals (Wren, 2003: 56-57).
private work by consultants would have to be off site or severely constrained … the consultants were never really going to go for that. …For example in the run up to the 2007 General Election, … the minister was getting very tired of the protracted nature of negotiations on a new contract and said … I am just going to put an ad in the paper to recruit new consultants and will do it on a contract that we think is fair. … Of course they went berserk about that and had a big meeting and a vote of no confidence in the minister and threatened not to cooperate with recruitment of people to these contracts not to serve on interview panels.” (IP, 13).

As such, the privileges granted to the profession in the aftermath of the Mother and Child policy debacle has come to be recognised as regrettable by modern policy actors in the Irish health care system. As a policy actor notes, the establishment of a one tier public hospital system with salaried medical practitioners would have been a desirable policy outcome by comparison to the complex interchange of public and private financial increments. Hence, aspirations to achieve greater efficiencies and equality in the Irish health care system are perceived to be greatly inhibited due to the state’s limited power base in the health care arena.

“Well like they are critical to everything and you know over the years … I would always be sorry that our GP’s weren’t salaried employees. I think that would make our life a lot easier in terms of you see other countries like the NHS, they would have much more flexible use [of] their GP’s because their… salaried employees. But you know our clinicians whether its doctors or any other professions are both devils advocates, resisters, they’re everything within the system… I mean overall our clinicians would be the biggest advocates of their patients. They certainly have vested interests and over the years some of the deals done have not been good use of taxpayers’ money and you know I think there is no secret in that and we’re trying to unravel a lot of those things now.” (IP, 22).

The source of the medical profession’s power in the Irish health care policy arena is thus perceived to be deeply rooted in the existence of the ‘Consultant ontract’. An agreement between the profession and government which has served to embed further the inherent inequalities present in the system. This primarily occurs through the institutionalisation of a dualist system of public and private forms of health care provision. In particular, the contract and wielding power of the profession is believed to demonstrate the limited
power which state policy actors hold in the advancement of ‘equality’ and ‘efficiency’ in the structures of health care delivery.

5.9 Impetus of the Health Act, 1970: reflections on its enactment.

The Health Act of 1970 proved to hold significance amongst participants as an evolutionary cornerstone in the development of the Irish health care system within the confines of equality and efficiency principles. One of the central precursors highlighted behind the enactment of this piece of legislation was structural in nature. As a policy actor suggests, the Health Act, 1970 aimed to provide an element of national configuration in the provision of health care. The administrative idea of developing a co-ordinated and national approach to the development of health policy in Ireland formed a central stimulus behind the enactment of this legislative act. Hence, this act was more concerned with achieving efficiency, through establishing a regional structure, rather than addressing solely issues pertaining to achieving outright equality of access to service provision.

“There was at the time a huge demand for regionalisation, not to produce better and more equal services but to be able to afford bigger hospitals with a wider range of disciplines and it was to facilitate that move that the health boards were set up in 1970. The Health Boards were not set up to guarantee greater access. They were set up to enable decisions to be made on a regional basis because the assumption was that not every town … could afford a big general hospital. [R]egionalisation of the health services was the first step. …[E]ventually it was decided that the only way we could do that was that we needed one unitary system” (IP, 1).

The objective of achieving efficiency in health care provision was largely put forward by the Fitzgerald report published in 1968. As a policy actor notes, the report was regarded as significant in providing a ‘road map’ for the future development of the Irish health services. The Health Act, 1970 was depicted as being symptomatic of an effort to rationalise the Irish health services from a localised county structure to a

\(^{62}\) This report proved to be of seminal importance in informing policy actors with respect to the drafting of the Health Act of 1970 (Barrington, 1987: 267-69).
regional institutional structure. This came to represent a ‘population approach’ to health care provision and the instilment of political accountability.

“I suppose by 1970, Fitzgerald had reported in 1968 … a new road map if you like for the organisation of health services particularly hospital services was being promoted which essentially meant that rationalising services into regions rather than counties. The county was no longer a sort of a meaningful or a large enough concept for the organisation and delivery of health care. It needed a bigger population approach while at the same time keeping an accountability, a political accountability etc. for the organisation and delivery in some meaningful way. ... The GMS scheme approach of the 1970 Health Act certainly pulled the primary [care] access issue together in a way that hadn’t been up to then.” (IP, 17).

The justification for regionalisation enshrined in the Health Act of 1970 is echoed further in the following quotation where it is reflected that the primary motivation, in efficiency terms, was geared towards the delivery of more succinct health care services. In particular, the concepts of standardisation and organisational structuration proved to be the impetus behind this legislation. Essentially, this sought to ensure, through the strengthening of the infrastructural base of health service delivery on a regional capacity, that the general population received a much more modernised form of acute and primary care.

“I think Childer’s, as far as I know was well motivated. He wanted to bring the situation to a better place by developing the health boards and providing more better care because you imagine the background to Irish health care was pretty appalling. You had a public dispensary type of system for the poor and so on and the system in many ways was underdeveloped and remained underdeveloped...” (IP, 1).

From the outset, the primary impetus surrounding the enactment of the Health Act, 1970 surrounded the instilment of efficiency in health service delivery. This was perceived to be particularly noteworthy in the administrative reform of the Irish health service and the transition towards a regionalised system of health care delivery. Therefore, the ideal of strengthening the infrastructural base and regional capacity in health care provision formed a central cornerstone to this reform agenda.
5.9.1 Health Act, 1970: Reflections on the status of equality.

Despite the core impetus behind the Health Act, 1970 centring on issues relating to structural efficiencies, some participants observed equality as a feature, albeit in a minimalist sense. As a health policy analyst notes, aspects of the health care system’s institutional structure, which were altered substantially by this legislative act, introduced provisos for ‘public hospital care’ and an assurance that the entire population had access to health care through the health board system. Thus, it is apparent that ‘implicitly’ rather than ‘explicitly’, equality exists in the structuration of health care provision.

“I guess the health act was quite equality … in that every citizen was entitled to public hospital care under it and the health boards was meant to provide a service for everyone. … [I]t was about providing health services for the population, so implicitly rather than explicitly it was meant … to have some concern with equality. But I wouldn’t have thought of it [as being] a primary concern.” (IP, 5).

Maintaining efficiencies in service delivery was also perceived to be a precursor to the extent of equality achievable in the system. As this policy actor points out, external and internal considerations, such as interest groups, pose as a significant predetermination factor in shaping the ethos of the Irish health care system. Hence, achieving equality in an absolute sense is regarded as not being ‘pragmatic’ and may lead to collapsing the health care system.

“I would think there was a strong concern but strong resistance likewise [to equality]. In fact, … I would say a strong concern for policymakers and legislators [was] to provide as much equality as possible but probably operating against the constraints of what’s possible and what’s pragmatic without collapsing the entire system and there are clear obvious interest groups that would be concerned that equality wouldn’t be the only issue determining access to health care which has obviously laid down the road to a sort of funny hybrid of systems [within the] public-private mix. Look at the Consultant’s contract for instance. It’s a rather unique point to end up with but obviously there for pragmatic reasons.” (IP, 17).

In terms of the policy construct of ‘eligibility of entitlement’ to public health care services, this was perceived to hold a limitation factor in terms of how much the
Health Act, 1970 could achieve in respect to the provision of egalitarian measures in policy implementation. As the following quote articulates, the concept of eligibility does not encompass a ‘legally enforceable personal right to health care’ but rather stipulates what can be delivered by means of health care provision within the confines of the resources available.

“…[T]he concept of eligibility [was] not a legally enforceable right to health care but actually a health care eligibility for services which would be constrained by what was the health sort of state were in a position to provide given their budget and that was a major changing point. The administrative arrangements to deliver that because in 2005, you know or 1999 there was the creation of the Eastern regional Health Authority, which didn’t change personal entitlements or eligibility and also in 2005 the creation of the HSE and the abolition of the Health Boards didn’t actually do anything in regards to the personal rights of the citizen, as citizen vis a vis the state and the state’s health care provision.... But it wasn’t about extending peoples personal rights or providing a rigid basis of equality.” (IP, 13).

While the eligibility or entitlement component of the Health Act is perceived to have had significant ramifications for the achievement of equality, some participants did hold a belief that a genuine egalitarian premise lay behind the establishment of the General Medical Service (GMS) system. As a policy advisor notes, through providing protection for the lower income groups in society, this is viewed as a legitimate effort to promote equality in health care provision. Furthermore, ‘equality of treatment’ was also believed to feature as a predominant concern through deconstructing the discriminatory barriers which existed in respect to the treatment of both public and private patients.

“From 1970 onwards…. doctors had to treat all patients in the same centres of practice and the notion of a separate dispensary for the poor was done away with. I think there … was a concern not to discriminate against the poor and to have them at least [visit] the same doctors [that] were treating the poor and the private patients. … [T]hat was one issue where equal treatment at least was on the agenda.... [Thus] the only evidence of a concern about equal treatment in the ’70 act is around the changes to the say in which the General Medical Service was organised. They didn’t change the wording about entitlement but they did change the conditions under which GMS patients were treated and I think that did stem from inequity, inequitable treatment of people with medical cards by Doctors...”(IP, 3).
In terms of analysing the Health Act, 1970 in a modern context, it is perceived that the act and all which it contains was not realised to the fullest extent. This resonates in particular with the findings of the Travers report and the scandal which arose following the illegal charging of the elderly in nursing homes. As such, the legislative provisos contained in the Health Act, 1970 (i.e. eligibility criterions) came to be interpreted by senior civil servants in a manner that did not encapsulate the overarching legislative intent of the act. As a public representative notes, this raises significant questions regarding the scope with which the Health Act, 1970 addressed the issue of equality and how much of this legislative enactment came to be realised in recent decades.

“… [T]he Health Act of 1970 I suspect it probably was very strongly emphasised on equality, but half the population didn’t realise the full extent of how that would manifest itself afterwards … [As the] system for forty years afterwards … kept muzzling the Act I suspect, never fully developing the Act. … [D]uring my time for example we embarked on under the health strategy of 2001 and...in 2002, … [an] intention to do ...[a] eligibility review. … [W]hat you are getting is an official’s answer and to be fair to the official’s throughout the ‘80’s saying we can’t afford this we can’t afford that so the Act can’t be implemented and then it became practice overtime… But the eligibility framework, I mean Michael Kelly would have said it is ill defined and so a whole lot was envisaged by the Act of the 1970 but actually took years to realise some of it” (IP, 9).

From the interpretations above, the concept of equality is perceived to have featured in an implicit rather than explicit sense following the enactment of the Health Act, 1970. As such, it was perceived that the achievement of an ‘outright vision’ of equality (i.e. through universal access) was not believed to be at the forefront of policy actors minds. On the contrary, maintaining the system proved to be a core concern. In addition, the idea of securing equality of access was not perceived to be a predominant policy issue for vested interests. Despite this, the GMS medical card in conjunction with the

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63 Commissioned at the request of the Minister to investigate charges imposed on residents in long term residential nursing homes over a 28 year period. The Report was published and presented to the Houses of the Oireachtas in 2005 (Connaughton, 2006: 254).
elimination of discriminative barriers between the treatment of public and private patients provided an element of equality in that it served to both protect and elevate the status of equality for the lowest income groups in society. However, the policy concept of ‘eligibility’ cannot be depicted as advancing a ‘legally enforceable personal right’ to health care, rather it served to establish the confines of free services in which the state was in a position to provide. Notwithstanding this, it was also interpreted that the scope of the Health Act in addressing egalitarian issues is ambiguous due to the principle of eligibility being perceived to be ill-defined in the subsequent decades following its enactment.

5.10 Health care provision in contemporary times: reflections on the administrative practices of the HSE.

The establishment of the Health Service Executive (HSE) agency was believed to be a revolutionary force that was to bring Irish health care provision into the 21st century. Essentially, this was perceived to occur within the theoretical and empirical realm of an ‘efficient’ and ‘quality driven’ service. It is apparent that the vast majority of participants viewed the establishment of the HSE as an attempt by government to correct the administrative ills created following the Health Act, 1970 and the consecutive health boards established. As such, the issues of: ‘political localism’; ‘incoherence and inefficiency in service delivery at national level’; and ‘geographical inequality with regards to accessing services’ featured as a predominant raison d’être for giving legitimacy to the establishment of a centralised and autonomous executive agency at ‘arm’s length’ from the Department of Health.

5.10.1 Health Act, 2004: disbandment of the Health Boards and establishment of the Health Service Executive.

At a rudimentary level, it was highlighted by participants that the health board administrative structure significantly impeded the power of government to implement policy and modernise the health care system on a national scale. As such, the concepts of good governance and efficiency were perceived as becoming redundant primarily due to the institutional design of the health board system. Hence, the issues of control and
the facilitation of change proved to be, as a former public representative notes, ‘almost impossible’. Therefore, the central impetus of government in establishing the HSE is believed to have been based on a desire to regain control of the implementation of health care services in terms of both the service delivery and fiscal management.

“… [T]he [health boards] became totally unwielding power centres and I found certainly right throughout the 1980’s that trying to do something with the health boards, the eight health boards around the country, almost impossible. They had chief executive officers, they had programme managers, they had principal officers in here, they had district officers here, they had district officers here, there and everywhere. Their budgetary systems were totally archaic. They thought nothing of running up deficits; let the Department pick up the deficit. They would run up deficits of 15 or 20 million each, each year… The system was very poor”(IP, 11).

This brings to the fore the concept of ‘fragmented governance’. As such, it was perceived that there was a prevalent ineptness in terms of being proficiently able to standardise health service delivery in the country. This was primarily due to what one policy actor describes as;

“…a sense that local politics was making it impossible to reconfigure local hospital services, politically, and I think with a sense in which it was seen as that it would be easier to go for centres of excellence if there were a central executive body.” (IP, 14).

Hence, the drive to achieve efficient governance and standardisation in service delivery became a predominant concern for government in establishing the HSE agency in 2005. As an academic commentator notes, the Irish health care system was overwhelmed with the interference from local vested interests. Thus, this institutionalised norm of ‘local political veto points’ had the effect of preventing a national health policy agenda and thus strengthened the argument for centralisation in the initiation and implementation of health policy.

“I think it was an identification of [not only the] fragmentation in the governance system but also undue influence upon local vested interests including political interests that led policymakers at the time to believe that by centralising the system they might both be able to introduce greater efficiency in the way the system as a whole was managed and be able to overcome what they saw
as these if you like local veto points that seem to be sort of structured into the system in an institutional way I think on both of them that they failed pretty miserably…” (IP, 6).

Furthermore, the localism enshrined in the health board structure led to variation in service delivery and proved to be a precursor to developing a centralist entity; the HSE agency. As a policy actor notes, this variation in quality and service delivery had important implications for equality of outcome regarding access to health care services. In essence, the variation which existed did not rest on the profile of the patient receiving care but rather the ‘difference in practice’ from one region to the next.

“… We needed a service that was coherent and hopefully more standardised with less variation across the country so [when] going into different settings you would get care of equal quality. A health service where decision making was not entirely constrained by local political interests, so the abolition of the health boards would have been informed to a degree by that. It’s not [that] local political interests don’t have a role to play but they don’t have a strangle hold. …But really … whenever you get many different aspects of health care you look at outcomes and data and … what you see across the country is variation. Variation in outcomes not explained by difference in types of patients … but just explained probably by difference in practice[s] that are not supportable. We need[ed] to confront and change [that] by giving standardised guidance as to what’s the best way of doing things [and] to bring everybody’s care up to the best care and only a national structure could achieve such a thing.” (IP, 21).

This variation in the quality of service delivered strengthened the argument for further standardisation and centralisation in the administration of health policy. Furthermore, there was also an apparent belief that the health board system enshrined a ‘geographical inequality’. As a policy advisor describes in the quote below, due to the level of autonomy held by each health board, regarding the implementation of health policy in its constituent region, this meant that patient entitlement diverged significantly throughout the country. The reference to inequality in a geographical sense proved to be predominant amongst a majority of participants. In particular, one policy advisor referred empirically to eligibility with respect to cancer care and home-help etc., whereby in one region a patient would be entitled to those services under a medical card whilst in other areas circumstances would be somewhat different (IP, 15 & 16).
“By 2005 or even a number of years before that there was a serious concern about very different levels of practice, different levels of availability of service and significantly different ways of doing things in different parts of the country. …[T]hat wasn’t automatically a bad thing but certainly for services outside the hospital system think of something like physio therapy, occupational therapy, dietetics;… your access to a service depended not on your eligibility but whether you happened to live in Donegal in the North Western Health Board or whether you lived in Drogheda in the North Eastern Health Board. There was no standardisation of eligibility; there was no standardisation of approach…” (IP, 19).

From the outset, the principles of standardisation and centralisation were believed to be an optimal solution in facilitating coherence and consistency in health service delivery throughout Ireland. Therefore, the primary impetus behind enactment of the Health Act of 2004, was informed by the desire of policy actors to achieve similar, yet interchangeable, principles of ‘efficiency’, ‘standardisation’, ‘consistency’ and ‘coherence’ in the delivery of health services throughout the country. In terms of equality and efficiency, a policy actor notes in the quotation below, that both principles must operate in tandem as a means of ensuring the optimal outcome for patients in access to health care provision. However, in the course of health policymaking, a compromise is sometimes struck which results in an unequal outcome of policy as a result of ‘choices’ made.

“So those kind of things and you had them no matter where you looked across every kind of type of service we provided was a key driver behind the 2004 reforms. The Brennan Report then would have been largely looking at efficiencies and value for money to be got by streamlining lots of our back office and really one stop shops for procurement and all that kind of stuff and added value. So again that would have been about efficiencies. But efficiency is about saving money to have more to offer. You know it all goes around in a circle. So for me I would always say everything to do with health has equality in the middle of it but choices means that things aren’t always equal and they won’t be. There will be inequalities in health care.” (IP, 16).

The principle of efficiency and governance in the implementation of health care services were thus perceived to be a predominant precursor behind the enactment of the Health Act, 2004. In dismantling the Health Boards structure, it was interpreted that the HSE
brought about an end to fragmented governance and in its place instilled the principles of standardisation, consistency and coherence in the delivery of health services throughout the country. Hence, the Health Act by institutional design was interpreted as bringing about ‘geographical equality’ in the Irish health service in that it served to eliminate variation in the quality of service delivery across each region of the State.

5.10.2 Health Service Executive: assessing the principle of ‘efficiency’ in service delivery.

From the outset, it is apparent amongst participants that the establishment of the HSE represented the dawning of a new era regarding delivery and efficiency in health service provision. As such, the establishment of the HSE on the health policy landscape is believed to represent a positive force in unifying the Irish health care system. Additionally, it is perceived that the ‘population health approach’ was developed further in health service delivery through a focus on issues such as: quality; standards; and data collection. This is depicted in the following quote whereby it is described how the process of unification and centralisation under the façade of the HSE incorporated the ideal of a coordinated and quality driven service into the Irish health service.

“…I think the HSE did advance the opportunity for a unified spread of quality, standards, data collection... I think for pulling together the entire medical card system all under the one single unified thing. The development of the most recent one would be the design of what they call clinical justice which is all of the clinical care programmes that are going on at the moment which means that all of the various areas whether it’s with cancer, cardiac, acute medicine, a range of other clinical programmes are all coordinated with the key players designing what is the best practice and then doing right.” (IP, 7).

The concept of centralisation proved to have significant resonance amongst participants who believed that consistency and coordination were central ingredients absent in the make-up of the Irish health care system prior to the establishment of the HSE. As the quote below explains, a sense of consistency emerged in terms of what the citizenry could expect irrespective of the region in the country where they reside. Hence,
consistency on a national scale was perceived to be a central theme in facilitating efficiency in the Irish health care system in contemporary times.

“Well it provided and ought to provide the ability to ensure greater efficiency even in terms of back office processing and that’s one area and in terms of having consistency of the provision of services across the country to be people as I say in community based services should be consistent. Consistency in terms of what people can expect in terms of home help, home care, nursing homes and so on. All that stuff should be done on a national basis and you know it’s not something that needs to be localised and it’s only fair to people that it is done on a national basis.” (IP, 13).

The concept of centralisation in public administration also came to symbolise a measure of success in efficiency terms amongst participants when analysing the establishment of the centres of excellence, such as cancer care. As a policy actor notes, the cancer care strategy and the intricacies associated with that policy initiative could not have been achieved under the guise of the health board structure. Thus, it is depicted that one of the core efficiencies to emerge out of the HSE’s establishment was the depoliticisation of health care in Ireland.

“…[E]ach Health Board would have its county jersey on all fighting to retain its local service. With the HSE, even though it was difficult, we managed to concentrate most of the major cancer services, like cancer surgery, in designated larger centres like UCHG Galway; Cork University Hospital; St. James’s; Beaumont and so on. We have designated hospitals. … [T]here’s absolutely no way we would have successfully centralised and concentrated those services in a smaller number of centres if we still had a Health Board system. There is no way we would have succeeded because each Health Board would have fought tooth and nail to protect its own. The fact that we had a HSE as one single national entity ensured that we were able to do that.” (IP, 19).

The primacy of this argument rests on the belief that rather than having hubs of small hospitals throughout the country, it would be more efficient and favourable for patient outcomes to have centres of excellence specialising specifically in cancer care. As one public representative described these centres would be an embodiment of where all the ‘cancer expertise is’ (IP, 9). Hence, the ideal of centralisation lends itself empirically to improving patient outcomes through clinical safety and the provision of
clinical specialists, in this instance, for cancer care. As such, the establishment of a national entity to replace the health boards structure was considered to be the most efficient means of delivering health care provision.

It is also perceived that the ideal of ‘centralisation’ also facilitated efficiency in the decision making arena. As a policy actor notes, decision making capability and implementation occur much more swiftly under the regiment of the HSE structure (e.g. efficient budgeting during times of fiscal stringency). This is in stark contrast to the health boards operational structure where prospective decisions would have to be conveyed and agreed with representatives of the ten health boards which thus inhibits effective decision making. Moreover, the consolidator properties of the HSE as a national entity were also thought to bring about efficiency relating to the acquiring of information and availability of data to policy actors in the Health polity arena.

“ We have taken out 2.5 billion over the last three years it would not have happened in the old world, it couldn’t have happened. [For] the Department of Health they [can now] speak to one group of people, the management team of the HSE or our other senior people, while they used to have to deal with ten health boards [which meant] every conversation have had to happen ten times. Now that conversation happens once. Something like the fair deal nursing home. [T]hat was [a] scheme that was dreamt up in the Department you know a new policy … and [officials] would have talked to one or two people in here how it might implement that and then those would have to come out and implement it around the country in one go. That kind of scheme would have been very difficult in the old world. (IP, 22).

However, despite the efficiencies referred to above, one policy actor stated that more ‘real time’ information is required moving forward in order to achieve optimum efficiencies in service delivery (IP, 20). While the standardisation of information is believed to be a significant attribute of efficiency to emerge from the establishment of the HSE agency in 2005, the national entity also proved to be equally significant in providing a singular voice to speak for the entire system. As a policy actor notes, having a singular voice to negotiate for the health care organisation generated significant cost efficiencies by contrast to the divergent negotiations that would have taken place under the health board structure. Thus, the efficiency achieved in this respect has been regarded as positive due it’s consolidator attributes enabling: the effective use of fiscal
resources; the provision of quality services; and most significantly a national approach to the ‘problem solving of services’.

“…[W]here the HSE advance the cause of efficiency and maybe greater cost efficiency in particular [would be in] the negotiations with the drugs companies and medicines from a single voice speaking for the entire system. [This] has brought substantial reductions in price for drugs and medicines which would be a big cost driver in the system and I would hope that in the structures that emerge. … I suppose Croke Park64 and the value of a National Approach to negotiating terms of conditions of employment particularly for non-basic pay, overtime allowances, roster, rotas, etc. There are opportunities there to speak with one voice and to deliver substantial efficiencies into the system that would be very difficult for individual sites and units to achieve.” (IP, 17).

The establishment of the HSE in efficiency terms was perceived by participants as a positive force in unifying the Irish health care system and developing further a ‘population health approach’ to service delivery. In particular, the process of ‘centralisation’ in the health service was believed to be a significant measure of success the development of efficiencies in the governance structure. As such, it is interpreted that efficiencies surmounted from the centres of excellence (i.e. cancer care) through improved patient outcomes and in the decision making process (i.e. budgeting decisions during times of fiscal stringency). Therefore, the process of centralisation and standardisation of information were believed to be significant in enabling the development of a singular voice to negotiate (i.e. with drugs companies) on behalf of the entire organisation.

64 The Public Service (Croke Park) agreement was a commitment by public servants and their managers to work together and change the way in which the Public Service conducts its business so that its costs and the number of people working there can be reduced whilst still maintaining services demanded and improving the experience of service users. The agreement covered the period 2010-14 and was reached with the Public Service committee of Irish Congress of Trade Unions (ICTU) as well as the representative Garda and Defence Forces Associations (Department of Public Expenditure and Reform, 2014).
5.10.3 Health Service Executive: assessing the principle of ‘(in)efficiency’ in service delivery.

While there is evidence to suggest that in theory the HSE represents a successful evolution to what existed previously under the health board structure, there are some proponents who hold the belief that the HSE is symptomatic of a “monstrous monolith doing very little for the health of the health of the nation” (IP, 8). In this context, the inefficiencies of the Irish health care system following the creation of the HSE far outweighed the efficiencies achieved amongst the opinions and perceptions of some participants.

As such, some participants argued that the HSE in its foundation was hindered significantly. This was considered to be primarily due to the pace with which it was set up. As a policy actor notes, the efficiencies which the HSE ought to have achieved were significantly impeded by the political process as well as the failure to rationalise in the context of human resources. Hence, the establishment of the HSE was carried out without due attention being considered for the intricacies associated with health care governance structures.

“… [I]t has failed quite significantly to achieve the greater efficiency that we thought it would. … There were a couple of factors which hindered that. Number one we absolutely rushed … into setting up the HSE on a legal basis. There was huge political pressure to set this up quickly. I think those of us in the Department would have argued it’s simply not ready yet and you know we should wait and get it right. But there was this project called “Go-Live ‘05” which was get the HSE up and running and operating from the 1st of January 2005… and I think that greatly hindered the way in which the HSE was set up. The other practical difficulty was that instead of having a national management team that would deal with the whole series of people who had been in the regional structures. So you had eight HR managers and eight finance directors or even ten of them and so on. And instead of saying well look we don’t need that number we artificially probably found jobs or found posts for different people so therefore we didn’t have a streamlined efficient system.” (IP, 19).

One health policy analyst in particular has stated that it precipitated “a perfect lesson in how not to reorganise the health system” (IP, 5). This primarily rests on a perception that the reorganisation process in the governance structure lacked
transparency. As this health policy analyst puts it, “everyone went into work that first week in January not really knowing who their boss was and spent ages sort of reorganising the chairs on the titanic with all these structures and forums.” (IP, 5).

The perceived inefficiencies to emerge can also be attributed to the belief that the rationalisation process, which in theory should have emerged from the establishment of the HSE agency, did not occur in practice. From this interpretation, it is observed that policymakers at governmental level did not assuage the potential efficiencies to be accrued through the centralisation process, primarily from the downsizing of human resources. Therefore, it is apparent amongst some participants that the political dynamics of impatience in establishing the HSE led to the ultimate long-term degradation of the agency’s governance structure in efficiency terms.

Hence, these political dynamics are understood to be reflective of the engagement and negotiation process with the Trade Unions in the lead up to the HSE’s establishment. As a policy actor notes, rationalisation in administrative practice did not occur. Instead, expansion of senior grades occurred whereby the individuals being appointed were not ‘shouldering greater responsibility’. Therefore, it is apparent that the theoretical ideal of centralisation and subsequent rationalisation became untenable due to intricacies in the negotiation process between vested interests and the political sphere, which in turn significantly impeded efficiency.

“…I don’t say this lightly because I am quite a socialist myself but “get rid of” all those pushing pen holders and all those people who are cloggin up the system. They were going to go on a national strike, IMPACT and SIPTU I think were the two trade unions. They were going to call a halt to the whole big onward stride of [the] wonderful HSE if they didn’t all get to keep their jobs. So there was no redundancies scheme, there was meant to be then, so Mary Harney tried to put a good face on it. There was a seamless pass-over from the health boards with [their] time wasting bureaucracy and they all transferred into the train station with HSE written on it, clouting for Dublin and that’s where it all ended up.” (IP, 8).

This failure to rationalise effectively led some participants to describing the inefficiencies to emerge as being reflective of an overburdened bureaucratic system, lacking in efficient structuration. In this sense, the concept of centralisation does not
become a cause leading to inefficiency in the governance of the Irish health care system. On the contrary, this interview participant points out that inefficiency was borne out of the organisation becoming excessively managerialist in outlook following the absence of rationalisation. Thus, the loss of control and power – by those in the front line services who have institutional knowledge in their own respective areas of expertise to influence policy – became the causal issue of inefficiency in the modern health care system.

“Well I don’t think that a centralised system need necessary be an inefficient system. I think the way in which the HSE was set up that it introduced a lot of inefficiencies. It seems to have been set up in a way that was very bureaucratic, very heavily managed in which the actual health workers, consultants, nurses etc seem not to have sufficient power to influence the way in which things are done in their own areas of expertise which seems a rather perverse way of setting up a system.” (IP, 6).

From the above interpretations, the predominant inefficiencies were believed to be borne out of the political haste at establishing the HSE coupled with the failure to engage in a process of Human Resources rationalisation. In particular, the inability to downsize human resources due, to political negotiations with the trade unions, is believed to have let to the long-term degradation of the HSE’s governance structure. As such, this is thought to have played a part in the creation of an overburdened bureaucratic structure with an excessive managerialist ethos in health service delivery.

5.10.4 Perceptions on the ‘inefficiencies’ which derive from excessive ‘centralisation’.

The loss of power has led to some participants commenting that the health care system, under the HSE’s remit, has become excessively centralised. Furthermore, it is depicted that the issues of control and taking of initiative at a localised level has become undermined thereby diminishing the potential efficiencies which could be achieved. In this sense, the ‘decision making chain of command’ was regarded as an inhibitor to facilitating streamlined efficiencies in health care delivery. As a policy advisor describes, having one centralised structure in the initial stages;
“frustrated an awful lot of the medical professionals and the senior people in the health service and they found that it was unwielding and they [also] found that no decision could be made and that’s what frustrated people in the initial phase, the first two or three years.” (IP, 16).

As such, it is believed that a balance needs to be struck in the context of those aspects of health care provision that needs to be centralised and what needs to be developed locally within the remit of health care professionals in the delivery of services.

“[W]hat the HSE tried to do was to centralise too much and wound up stifling if you like local initiative, local control, problem solving you know along the chain of command approach which probably damaged the empowerment of local services, hospitals, primary care units and I think …the structures can either advance or hinder efficiency and the trick here and the secret to this is to centralise what should be centralised for efficiency and not to go over board and pull it all in and pilling too much into a central control model as we have seen over the last five or six years can stifle flexibility speed quick decisions, empowerment, which are things that are needed to deliver [a] responsive systems that deal with patients effectively.” (IP, 17).

Furthermore, the centralisation process has also acted as a preventative measure in facilitating efficiency in the allocation of resources. This is based on a perception that a ‘disconnect’ exists in the decision making process between the administrative tier and those in the frontline staff. Therefore, the object of creating a centralised hierarchal structure whereby decisions are made at the top of the organisational pyramid is believed to result in an ignorance of what is occurring in clinical practice.

As such, participants were unanimous in the belief that the managerialist ethos of the HSE created inefficiency in the daily operations of the organisation due to: the political dynamics and the external vested interests; the stifling and disempowerment of local initiative on the ground; and finally the disconnect which exists between administrative decisions taken without due consideration for what was occurring in practice.

“Now the vast majority of, the allocation of resources follows the decisions the GP’s take when they diagnose and refer patients or treat patients. So the further you remove decision making from what’s happening on the ground the greater the disconnect between the clinical care of patients
and the administrative framework…So you need the decision making structure that is actually very close to where the action is in the health service and it’s no coincidence I think in Britain that they very much gone back to an administrative structure that focuses a lot of attention on, gives the budgets to, the budgets for health care to GP’s and the GP’s are deciding where to refer patients based on the best service they get.” (IP, 3).

The inefficiency cited in this instance appeared to be exasperated further when coupled with the complex structuration of the HSE organisation in the delivery of health care services. As such, it is perceived that the ‘silo structure’ lacks co-ordination and connectivity between the respective pillars of service delivery. Furthermore, as a public representative notes the ‘silo system’ is also believed to have introduced rigidity into the system as it has not functioned sufficiently in addressing issues outside its pilloried remit.

“I think … the kind of silo thing you know where you had the acute section and you had the primary, community, continuing care any you had, other areas then got neglected because they didn’t have a proper silo like mental health and children which is now being moved into another Department. So I think it was an imperfect system that was set up that didn’t have the proper connections across, everything was up and down and it also, I mean it’s always going to be difficult anyway when you are trying to rationalise something like a health service and the local hospital issues.” (IP, 12).

It has also been observed that the HSE since its foundation has been expansionary in the delivery of diverse services under its centralised organisational structure. This has led to it becoming less manageable and inefficient. As one former policy advisor argues, it can be disputed that while there may have been an argument to establish an agency to run acute aspects of health care – e.g. the nation’s hospitals – this is not necessitated for non-acute services to the population – e.g. disability services. Therefore, it is perceived that more efficiency could have been achieved had services been delivered in a more systematic and manageable unit manner – through focusing exclusively on medical needs in the arena of hospital and primary/community care.

65 “A system, process or department etc. that operates in isolation from others.” (Oxford Dictionaries, 2015)
“… So there might have been an argument for a model that involved, let’s say three national agency [structures], if you had hospitals, if you had community care/primary care and if you had community services that might have [been] manageable, it might have been manageable and it might have been more efficient and there may have been enough management personnel to sort of split them among three. But what was done didn’t do that, there was not attempt to do that.” (IP, 1).

While in theory the practice of centralisation was thought to lead to efficiencies emerging in the delivery of public services, participants nonetheless interpreted the process as being a contributing factor leading to inefficiencies emerging in the Irish health care arena. This was particularly noted in the observation that a ‘disconnect’ exists in the decision making structure between the administrative sphere and the frontline at local level. As such, the managerial ethos of the organisation has created what is believed to be a disempowerment at local decision making level. Furthermore, the centralised nature of the Irish health care system following the enactment of the Health Act, 2004 has led to a belief that the HSE has become over extended in respect to vast roles and responsibilities in the delivery of social services under its remit. Therefore, potential efficiencies could have been better achieved had the HSE a sole focus on ‘medical services’ in the arena of primary and acute hospital care.

5.10.5 Perceptions on the ‘inefficiencies’ to derive from the managerial structures of the HSE organisation.

When analysing the operation of the HSE in an organisational context, some participants highlighted the internal managerial structure as a source of inefficiency in the delivery of health services. As a health policy analyst notes, the operative practice of management is perceived to have been weakened following the transition of administrative power from the health boards to the HSE agency. In this sense it is articulated that under the health board system, an alliance existed between the political and management forces which was considered to be beneficial in efficiency terms. However, with the establishment of the autonomous HSE agency at arm’s length from the Department of Health, this alliance became effectively diminished. In addition, it is
observed that while the medical profession’s power may have appeared contained under the old health service regime; their power grew exponentially following the collapse of the previous politico/administrative alliance. Therefore, in this sense it is believed that the inefficiency in the current context may have resonance in the change in power dynamics following the establishment of the HSE agency.

“…what I am cross at is that the role of management in the health service has been greatly weakened and if there are I suppose three forces and there is the management forces and management has been hugely weakened in the Irish health care system. Politically, the political influence, the politicians may not have seen it but their alliance is normally with management rather than with the medical profession. Now the medical profession is I would suggest even stronger in the system than it was when the health board system was there when you had medical interests modified by an alliance between the political system and the management system. Now the management system has been hugely weakened, the political system I suspect lacks power to actually do anything and the medical power brokers will be even stronger than ever.” (IP, 3).

At a more localised level of management, it is considered amongst some of the participants that hospital managers play a crucial and detrimental role in the achievement of efficiency in the delivery of health care services. As a policy actor notes, the management of hospitals in an individualised manner represents a significant precursor to the achievement of optimal efficiencies in our health care system. As such, it is depicted that inefficiencies can also stem from the lack of skills and expertise in hospital managers to deliver optimal efficiencies in the health services on the frontline. Hence, while the HSE provides the ‘framework’ to achieve efficiency; it is actually those who deliver the health services on the ground where efficiency can fully come to fruition.

“An awful lot has depended on local management … It’s a real skill and that has had a very poor effect on cost effectiveness in different hospitals. So [the] HSE system offered you the potential to improve efficiency and some areas it certainly achieved it and in other areas it didn’t. But if you take the most recent initiative which is to establish hospital groups and in fact where you are in Galway there is a hospital group with a single hospital manager group chief exec with responsibility for a number of hospitals with a single director of HR, a single director of nursing and responsibility for managing a group of hospitals delivering within budget and delivering
within a defined number of whole time equivalents we call them you know staff and I think that is the way forward and something like the HSE with a group of hospitals operating underneath it has significant potential for efficiency in that regard.” (IP, 19).

The structuration of management according to the above interpretations also acts as a significant precursor to the instilment of advanced efficiencies in health service delivery. In particular, it is noted, by comparison to the ‘old’ health board regime, that management has been greatly weakened. This to a significant extent is believed to be in response to the establishment of an autonomous HSE entity and the breakdown in the political-administrative alliance that existed previously under the health board structure. As such, this weakening of management is thought to have strengthened the power of vested interest, such as the medical profession, in the health policy arena. Furthermore, it has been interpreted that managerial inefficiencies also surmount from not only the administrative tier of the HSE but also the failure of local management level to uphold responsibility in the delivery health care services.

5.10.6 Assessing the ‘inefficiencies’ borne out of the loss of accountability and democratic oversight on HSE operational practices.

The concept of empowerment has been highlighted by participants regarding the administrative practice in which full-operational responsibility for the delivery of health services came to be devolved to an autonomous agency. As a former public representative notes, the somewhat un-clarified relationship which exists between the Department and the HSE agency has meant that identifying responsibility in health care delivery has evolved to become increasingly precarious. This is prevalent in regards to issues such as determining ‘equality’ of entitlement, which is no longer the prerogative of the Department of Health under the current guise of the executive and operations policy divide. Therefore, this leads to a consideration of the level of empowerment that the Department of Health possesses to influence the manner in which health policy comes to be executed.

“Mary Harney as a Minister of political expediency, devolved accountability from the Department of Health to the HSE to ensure efficiency and greater equality. The question then
arises why a Department of Health budget? In principle, the HSE structure is un-contestable and its relationship with the Department is undefined. The Department is the determinant of policy and the HSE the executive implementation of the health budget. Where does the Minister interpose? Who determines ‘equality’ of entitlement?” (IP, 11).

The transition of power over executive matters to the HSE from the Department of Health has also raised significant questions relating to accountability and democratic oversight in the health policy arena. As a former policy advisor notes, due to the design of the system with its perceived layers and sub layers of administrative levels, accountability has become lost in the maze of the bureaucratic system. This has led to a belief that the bureaucratic structure of the HSE has also impeded the advancement of ‘equality’, ‘equity’, ‘fairness’ and ‘efficiency’ in the delivery of health care services.

“There are so many levels and so many steps that can in the end of the day [there can] be no accountability. It just isn’t possible for there to be accountability because that is the way the system was designed. And you can't have equality, you can’t have equity, you can’t have fairness, you can’t have efficiency if you don’t have accountability. So they have designed a system where none is possible. So that is a really significant development in my view, in the evolution of the health system and it has led to a model where the things we want to achieve and the things we give lip service to aren’t possible because the design of the system does not allow it.” (IP, 1).

The issue of accountability in the post-HSE era has also featured as a predominant concern in respect to the ability to question the agency’s operations in the parliamentary process. As one former health policy analyst and policy advisor described;

“I think that there were fundamental questions about the division between the setting of policy and the role of the executive. Central questions about democratic oversight and the role of the Dáil which were not properly sought through in its establishment.” (IP, 14).

Accountability and the democratic oversight through the Parliamentary process have been sighted as a serious concern amongst some interview participants. As a policy
actor notes, there appears to be powerlessness from a parliamentarian’s perspective to retrieve answers on executive matters in the delivery of health services.

“...it was a major reform measure that was based on false analysis of what the problems were and Harney, she then had the HSE operating in a semi-autonomous way and she would stand up in the Dáil and say oh well that’s the HSE’s problem and even the TD’s couldn’t get answers which really annoyed them because one of the missions in life is to get...answers and so on.” (IP, 19).

At a micro level, some participants raised concerns surrounding transparency with respect to the financial aspect of health service delivery. As a health policy analyst notes, inefficiencies arise out of there being no apparent linkage between what is spent and what is achieved in health care spending. Failure to provide transparency makes it difficult to put ‘resources in areas of need’ due to the perceived ineptness between linking strategically what is spent and the outcomes achieved from that source of spending.

“...[T]here is not a national system [similar to that] constructed on an OECD basis which shows precisely what programme spending is and what employment is in different programme areas within health and social services. The fact that we don’t have that I think is a really serious failing of the system and it leads itself to a great lack of transparency about health spend which in itself fosters inefficiency and also makes it very difficult for the case to be made for greater resources in areas of need because there is no clear linkage between what we spend and what we achieve in health spending” (IP, 14).

The inefficiencies which arise in financial terms also resonate with what has been described as the existence ‘historical sources of funding’. As a policy actor notes, aspects such as efficiency in both the delivery of health care services and also in the enshrining of equality are to some extent been predetermined by the sources of funding which existed under the health board structure. Hence, the element of variation which existed under the façade of historical spending has led to the exasperation of inequity in the services delivered across the country.
“…the National Health Delivery System whatever it’s called can clearly and must play a role in enhancing equality so that means that it needs to also start to shift resources around the country in such a way that there distributed in relation to need because there are all kinds of historical funding. Certain places are funded more for some service than another and that’s all historical variations in how our services is equitable you need to fund in relation to need and not in relation to historical patterns of spending. So that’s something that a national system will still need to address and continue to address.”(IP, 21).

The inability to exercise of accountability and democratic oversight to the fullest extent are thus perceived to be another significant precursor leading to the growth of inefficiencies in the Irish health service. In particular, this is perceived to be borne out of the autonomous nature of the HSE agency coupled with the formal policy and operations divide in the health care system. As such, it has been observed that the Department of Health has become somewhat disempowered due it no longer controlling aspects of policy execution. This loss of accountability is exasperated further with regards to the powerlessness of parliamentarians to exercise democratic oversight in respect health service delivery. Due to the bureaucratic features of the HSE’s organisational structure, accountability is also believed to have become lost in the system which in turn calls into question the ability to instil principles of equality and efficiency in service delivery. Furthermore, the lack of transparency is also thought to act as a contributing factor to arising inefficiencies in terms of addressing historical sources of funding and the strategic linking of spending with policy outcomes.

5.10.7 Public perceptions on the performance of the HSE: role of the media and corporate branding.

The interview findings have also highlighted observations pertaining to the manner which the media has tended to report on the inefficiencies delivered by the organisation more so than the efficiencies achieved. Thus, the media is perceived to exasperate all that is negative in the HSE’s activities rather than what is positive regarding health service delivery (IP, 21, 22 and 13).

Furthermore, the concept of corporate branding has featured as a predominant concern in that it has led to inefficiency becoming a permanent label being attached to
the HSE agency. As one policy actor suggests, the branding of the HSE as a corporate entity is believed to engrain a blame culture towards upper management with regards to all the wrongs and systematic inefficiencies which arise in the course of health care provision. Hence, it is suggested that the lower layers of the health care institution fail to take responsibility for its respective actions.

“… [T]he use of the term executive and the ‘e’ in the HSE I think was most unfortunate because it reinforces this concept … of [a] distant ivory tower group who are running the health services, who are devoid of any understanding of how health services are actually delivered and I don’t think that’s true in reality certainly not from my case… [B]ut it is a perception that we have to overcome and its made the HSE … a kind of lightning rod for criticism for everything that happens. … Whereas I think responsibility is a concept that is much better understood as being a shared concept whereas obviously nationally we have certain responsibility … But locally people [have a] responsibility to deliver what they [are] asked to deliver and to behave professionally as individuals and as collectives …” (IP, 21).

This sentiment has also been echoed by other policy actors and public representatives. In particular one former policy advisor cited the political sphere as being facetious in honing in on the HSE, particularly the upper management tiers, as the perceived source of all ills produced in our nation’s health care system.

“…[T]he HSE has provided some greater degree of efficiency and you have to look at it in terms of the facts rather than the media reports or indeed the political rows about it because it provides a very handy whipping boy for politics in the last five years or since it came into existence.” (IP, 13).

From this interpretation, the media portrayals and the corporate branding of the HSE agency are believed to have exasperated the public perception of the inefficiencies occurring in the organisation of health care delivery. In particular, the corporate branding of the HSE has led to public criticism being directed towards the upper management tiers of the organisation rather than observing ‘responsibility’ as a vast concept which also incorporates local hospital management level in the delivery of services.

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5.10.8 Contextualising the status of ‘equality’ in the Health Act, 2004: Reflections on the extent to which the HSE instilled ‘equality’ in the delivery of health care services.

When contrasting the eras between the enactments of the Health Act, 1970 with that of the 2004 Act, some participants highlighted a stark distinction in respect to the vision of equality applied in health service provision. As such, it is believed that the societal vision of equality from a policymaking perspective has undergone a significant transformation. This shift in focus is believed to have moved from a theoretical position where equality is visible in the provision of a basic service to one in which equality is depicted in the delivery of a quality and standard driven service.

“…I think in 1970 the concern was more about not having people be deprived the service you giving some kind of basic service to people who are needy whereas the thinking in 2004 onwards is much more around the genuine equality approach. I think it is a different kind of frame of mind … and it would be the same in other aspects of Irish life where we have a more sophisticated concept now of how equality works … that you don’t automatically assume that certain people are in certain social categories and others are having entitlement to different standards and qualities of service.” (IP, 12).

Furthermore, it has also been highlighted that the concept of equality was not observed by the vast majority of participants to be a predominant aspect on the legislative agenda of the Health Act, 2004. Rather, as the policy actor explains in the following quote, it was the ideal of instilling a sense of accountability which was the primary stimulus behind its enactment. Thus, it is depicted that the primary policy paradigm in operation was one that focused on issues relating to governance, management and accountability.

“The concept of equity has developed overtime certainly since 1970. Although I think the focus of the 2004 Act was less to do with equity per se and more to do with setting up the health service executive and setting up a better accountability provision whereby the health service executive would be required to develop a service plan, approve it with the minister, show what it will be spending its money on an link the amount of money being spent to the outputs being produced…I think it is true to say that the concept has developed to and it has moved on overtime. But at the same time we are dealing with a small proportion of the population and the total population in terms of public access to services.” (IP, 19).
The predominance of administrative reform over the issue of equality has been asserted further by a health policy analyst where it is stated that the Health Act of 2004 and the concurrent establishment of the HSE;

“…didn’t really change anything in terms of the ordinary person going to the Doctor or needing hospital care. It just changed the structures that oversaw those services. So in a way it had nothing to do with equality” (IP, 5).

Some participants also cited the administrative reforms as being resonant of an attempt to achieve greater equality within the structures of health service delivery – through the instilment of efficiency and quality standards. As a policy actor notes, the administrative reforms ought to have enhanced geographical equality and eradicate divergences in efficient service provision (evident in the health boards structure) throughout the country. Therefore, the HSE as a national agency was to facilitate equality through the standardising of services provided to citizens throughout the country.

“Well I think that…in my view where we are in this discussion distinguishing between formal rights under legislation is one thing, the administrative systems don’t really influence your formal right into the what can you go into court and say with the state on the other side of the argument. But the administrative system however can impede or facilitate the provision of a quality service which is effectively equal no matter where you live in the country by being well organised and being efficient. When we had separate health boards there was a divergence in efficiency, some of them would be good at one thing others would be good at another. But when you needed a national policy on a thing like cancer, a lot of people lost out on that. So it does effect equality in that respect.” (IP, 13).

Among other participants, the cancer care strategy has been cited as a primary example demonstrating this egalitarian ethos through efficient service delivery. As such, the HSE is presented as an efficient and equitable medium in which policy initiatives in areas such as cancer care, cardiovascular care and other clinical services can be provided to the citizenry on a national scale. Thus, it is believed that equality can flourish not only
in the standardisation of services available but also through ensuring that patient outcomes across the country are enhanced in an equitable manner.

“...[T]here is no way that you would have had the quality of service through centralisation and specialised designated cancer centres if you didn’t have something like the HSE and maybe to broaden the concept of equality ... [E]quality is to do partly with ensuring that everybody has access to services but to quality services. In other words, making sure that people have not just a basic service but a service that is of a high quality, that ensures that they have the best possible outcomes or gives them the chance of the best possible outcome and cancer [is an example of this]. [The] HSE has done a lot of good work on cardiovascular services and also the ... clinical service groups...All of these are HSE driven initiatives partly from the centre but then developed locally as well which have significantly improved the scope for equality and equity of access in the Irish system.” (IP, 19).

Furthermore, the HSE has also been reflected as an instrument of the power held by an incumbent Minister and the ideological persuasion which he/she possesses while in office. Essentially, the Minister and senior personnel at Departmental level are perceived to have pursued a policy trajectory that encompassed values not akin to achieving greater equality in health care provision. On the contrary, the values held by policy actors favoured ideals of privatisation and co-location.

“The HSE responds to the policy direction of the Minister for Health and the HSE was set up by a particular Minister for Health Mary Harney who remained then as for Minister for Health for a long period afterwards and ... her policy direction loomed large... [I]t was a policy direction that did not pay any real attention to issues of equality in my view. ... I think Mary Harney as Minister and the HSE ... was running [a] system during that period that ... sought to resolve issues of provision by a policy of privatisation. The issue of co-location springs to mind and I think that entrenched in a deeper way issues of inequality. So far from the HSE trying to resolve problems of inequality I think it ended up actually exacerbating the situation in quite a fundamental way actually.” (IP, 6).

In terms of contextualising welfare provision moving forward, it is perceived that there is an emerging appetite to decentralise social services (e.g. provide services locally in the community by voluntary sector non-profit organisations and the private
sector combined.) From the quote below, a policy actor describes how the concepts of ‘personal responsibility’ and ‘community responsibility’ are essential features under a decentralised model.

“… [The welfare state is] now not affordable and rowing back is a major … challenge. While in Portugal the state really has nothing to give anybody and everybody helps to look after everybody …[Y]ou can’t get rid of personal responsibility and the community responsibility and I would be a big believer in [the] community staying involved in looking after their own patch which is where decentralisation might improve more. So I [support]… a decentralised welfare state because there is … local ownership there.” (IP, 22).

In contemporary times, the focal point of equality, in an explicit fashion, was not perceived to be at the forefront of the legislative policymaking agenda. Rather the core emphasis has been placed on reforming the structuration of the Irish health service, enhancing accountability and the delivery of a quality driven health care service. However in an implicit sense, it was interpreted that the administrative reforms facilitated geographical equality through the removal of divergences in service delivery that existed under the health boards structure. Furthermore, the standardisation of health care services (e.g. cancer care and cardiovascular care) under the HSE’s remit was thought to broaden the concept of equality through facilitating the enhancement of patient outcomes across the country in an equitable fashion. Despite this, the overarching reform agenda was not considered to be outright egalitarian in that it did not alter the ‘formal rights’ or ‘entitlements’ of citizens in respect to accessing health care services. In part, the absence of an outright egalitarian agenda in health care reform rests on a belief that the existing values system in the policymaking sphere are not akin to achieving greater equality in the Irish health service. Rather, it appears that the policy sphere is directed towards an emphasis is being placed on ‘personal’ and ‘community’ responsibility in the domain of service delivery.

5.11 Conclusion
This chapter presented the interview findings from this study. When interpreting equality in health care provision, participants favoured a framework in which access to
health care services would be provided on the ‘basis of medical need’ rather than ‘ability to pay’. Theoretically, there is no concise definition of what equality encapsulates in policy documents such as; Quality and Fairness: A health care system for you. Despite this, the general consensus amongst participants was that a Rawlsian conceptualisation of ‘equality of opportunity’ proved to be the predominant framework dictating the governance structure of health service delivery. In practice however, this theoretical variant was considered to have a limited scope in terms of achieving outright equality in service provision. This is reflected in the perception that the primary objective of this egalitarian framework is to provide ‘basic access’ to health care services. Furthermore, an outright vision of equality has become constrained further through the existence of ‘equity’ as an operative framework in Irish health policy. As such, this variant has been depicted as a watered down vision of equality in that it primarily emphasises on instilling a spirit of fairness in determining access to health care services – e.g. the GMS medical cards for the lower socio-economic groups. Hence, the findings depict that the theoretical constructs of ‘Equality of Outcome’ and/or ‘Equality of Condition’ which aim to equalise the health status across all individuals and social groups in society becomes redundant due to the reinforcement of ability to pay as a principled determinant of access.

The defining evolutionary periods of significance in the Irish health care system are believed to be: Poor Laws era; the establishment of the dispensary system; and 1940’s decade which witnessed the rise of vested interests in the health care arena. In terms of the Poor Laws era and the dispensary system, the findings reveal that these periods proved to be significant in establishing the distinction between ‘public’ and ‘private’ patients in tandem with an infrastructural baseline to health care provision. The 1940’s period proved to be pertinent in providing an ‘access point’ and ‘fertile ground’ for vested interests involvement on the institutional stage of policymaking. As such, the Catholic Church and the Irish Medical Profession were cited as being resistant towards the development of a one-tier publicly funded health care system. More significantly, it has been observed that the initial access point granted in the 1940’s decade has served to empower the medical profession as a dominant broker on the institutional stage of Irish
health policymaking. This power is thought to be particularly reflected in the existence in modern times of legislative arrangements such as the ‘consultant contract’, which has sustained the two-tier system of access to health care provision.

The Health Act’s, 1970 and 2004 have been depicted in the findings as enactments primarily concerned with advancing efficiency in the governance of the Irish health care administration. As such, equality came to be interpreted in an ‘implicit’ rather than in an ‘explicit’ outright egalitarian manner. For instance, the existence of the GMS medical card for the lower socio-economic groups since the 1970’s has been interpreted as a ‘purposeful’ or ‘paternalistic’ egalitarian premise in that its primary policy emphasis is on directing public health care services towards the lower income groups in society rather than establishing universal entitlement. In modern times, equality is also perceived to exist in an implicit sense. As the centralised HSE agency facilitated geographical equality through instilling the principles of ‘efficiency’, ‘standardisation’ and ‘consistency’ in service delivery. Furthermore, the efficiency epitomised through the ‘centres of excellence’ programme was perceived to instil equality through the achievement of positive patient outcomes. Despite the objectives of the Health Act, 2004 and its establishment of the HSE agency, inefficiencies has also been depicted as a defining characteristic of health care provision in modern times. In particular, the failure to engage in a process of rationalisation following the disbandment of the health boards and the managerialist ethos of the HSE organisation has been cited as the core sources of inefficiency to emerge in contemporary times.

In the following chapter, a discussion of these findings will be presented relating to the relevant literature on Equality and Efficiency theory and Institutionalism theory.
Chapter Six

Discussion:

Assessing the theory and practice of equality and efficiency principles in the Irish Health Care System.

6.1 Introduction

In this chapter and the subsequent (Chapter Seven), the findings of this study presented in Chapters Four and Five will be discussed in the context of the literature presented in Chapters Two and Three. For the purposes of structuration, the research findings will be discussed in relation to the corresponding research objectives.

From the outset, it is evident that contemporary policy documents and legislative enactments surrounding the development of the Irish health services has proven to be ambiguous in outlining the philosophical ethos of equality adhered to at both a policy and Departmental level in the Irish health system (Smith, 2009: 5; see chapter 2, section, 2.5). On the basis of this foundation, the core research question of this study aims to critically examine the current policy practice and ethos of ‘equality’ shaping the structures of health care provision. Furthermore, this study investigates if a philosophical principle of equality features as a predominant facet influencing both the policymaking environment and consecutive reforms of the Irish health service. In addition, this study also seeks to explore if the desire to achieve ‘efficiency’ in the governance structure of health care provision supersedes the achievement of outright ‘equality’ in service delivery.

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66 e.g. Quality and Fairness: A health system for you (2001)
67 e.g. Health Acts, 1970 and 2004
The following are the core objectives of this study in relation to the policy and practice of equality and efficiency principles in the Irish health care system:

1. What evidence is there to suggest that the concept of equality features as a central tenet influencing the policymaking environment of the Irish health care system?

2. In analysing the legislative enactments of the Health Acts, 1970 and 2004, what evidence is there to suggest that ‘efficiency’ in the governance structure formed a principled tenet during these periods?

6.2 General discussion of findings.

When conceptually defining equality in contemporary times, it is evident that the Irish model of health care provision can be characterised as a ‘mixed-motives’ system. The study findings posit that this ethos contains both egalitarian and libertarian sentiments. Egalitarian features (such as equality of opportunity) are primarily visible through policy constructs such as ‘eligibility of entitlement’ and ‘income means-testing’ which ensures that the poorest and most vulnerable in our society have access to ‘free’ publicly funded health care. Whilst in a libertarian fashion, the middle-upper income groups fend for themselves through engaging with the private sector (i.e. engagement with the health insurance market in meeting their demands for health care services). Therefore, the primary egalitarian ethos pursued is one which advocates the ‘taking care of the needy’ while the wealthier sections of the population fend for themselves. In an evolutionary context, this study has found that health care reforms have consistently upheld this ‘mixed-motives’ framework. As such, this superseded attempts to introduce an outright vision of equality through universal entitlement to health care.

In recent decades, the instilment of ‘efficiency’ in the governance structure of health care provision far supersedes the objective of achieving ‘equality of outcome’ across all income groups in society. As such, this is based on a policy conception that through achieving efficiencies in the development of a population health approach to
service delivery in tandem with quality and safety in patient care facilitates, *equality* is thought to emanate through the treatment received (e.g. establishment of the Centres of Excellence in each province of the country). From this standpoint, there has been an egalitarian shift towards the instilment of *equity*; whereby the primary ethos is to infuse fairness in regards to the structures of service delivery. As such, this conceptual framework has served to reinforce the ‘mixed-motives’ status quo. This is based on the fact that the ideal of ‘fairness’ becomes redundant within a system which is organised according to conflicting idealisms of equality of opportunity and a libertarian vision of individualism. As the research findings reveal, the continuance of the public-private mix of two-tier access and eligibility of entitlement have best served to exasperate inequality regarding access and entitlement to health care provision.

6.3 What evidence is there to suggest that the concept of equality features as a central tenet influencing the policymaking environment of the Irish health care system?

When contextualising the presence of ‘equality’ as a central tenet in the evolution of the Irish health services, the study findings have revealed that the process of conceptualisation has proven to be ambiguous. As such, this to a significant extent owes its origins to the ‘mixed motives’ system which emerged during the evolution of Irish social policy (Smith, 2009; see chapter 1, section, 1.1). In terms of its application to the Irish health care system, it has been stipulated that there are some elements of provision governed with an egalitarian intent while libertarian principles govern other aspects of its operational structure. While there is no evident ‘policy commitment’ to an egalitarian ethos in health service delivery, the research findings indicate that the institutional structures of the Irish health care system nonetheless evolved to incorporate attributes reflective of Rawls theory of equality (1971) in tandem with a libertarian emphasis. The principles of Rawls theory of social justice in this respect can be observed through the ethos enshrined in the public hospital structure and the GMS medical card. While libertarian tenets are enshrined in the existence of the Irish health insurance market and the private hospital system.

In the subsections below, it will be depicted how the Rawlsian premise of social justice in conjunction with the libertarian principles of individual freedom and the
private market came to be instilled in the Irish health care system. As such, it will be articulated how equality of access and outcome in receiving treatment ‘according to medical need’ came to be significantly constrained. This is reflective of the ‘mixed-motives’ character of the system which implanted the principle of ‘ability to pay’ in health service provision. The latter part of this section will discuss the concept and practice of equality in contemporary times. In particular, it will be articulated how the Irish health care system in a modern context espouses towards an egalitarian vision of equity. From this perspective, the study findings have indicated that this conceptualisation is not attributable to an ‘outright’ vision of equality. On the contrary, it has the primary intent of instilling a ‘spirit of fairness’ in the structuration of health care provision as oppose to a principle of ‘universal access’ on the basis of medical need. As such, the current framework which emphasises on the achievement of fairness in the structures of the Irish health care system has also been a source preventing an outright egalitarian premise coming to fruition in the system.

6.3.1 Libertarian and Rawlsian conceptions of equality: Implications for Irish health service delivery.

Within the libertarian tradition, it is evident that the primary emphasis is on enabling the exercise of individual rights. By implication, this asserts that if everyone is entitled to the ‘good’ which they possess, a ‘just’ distribution by definition is one that emanates from an individual’s free exchange of those goods in the market place. From this stipulation, the principle of distributing social goods such as health care through the market place (i.e. Private Health Insurance) according to a precept of willingness to pay comes to be derived. The practicality of this form of service provision results in a direct linkage between the payment of and consumption of health care services (Smith, 2009; see chapter 2, section 2.3 and 2.5).

By contrast, the Rawlsian conception of social justice has been found in the findings to promote the distribution health care in accordance with the needs of individuals with the worse health status (Smith, 2009; see chapter 2, section 2.5). When putting into context Rawls theoretical derivations of the ‘original position’, ‘veil of ignorance’, the ‘difference principle’, and ‘fair equality of opportunity’ it becomes clear
that that the central goal of this egalitarian perspective is not to eradicate inequalities through a system of ‘redistributive justice’. Rather, it sets as its prerogative the eradication of poverty in society. As such, this is symbolic of precisely where the ideals of ‘equality of opportunity’ and the ‘setting of the minimum floor’ in social policy comes to fruition (Callinicos, 2000; Kymlica, 2002; Rawls, 1971; see chapter 2, section, 2.3). To a significant extent, this theoretical position is consistent with the rise of citizenship rights whereby the central intent was to incorporate members into society in an inclusive fashion through granting ‘equality of opportunity’ in access to social goods such as health and education. However, this occurs without destabilising the more fundamental inequalities in a modern capitalist society, such as income and wealth (Turner, 1986; Sullivan, 1998; see chapter 1, section 1.3.1 and chapter 2, section 2.2 and 2.3).

The idealisation of the ‘minimum floor’ in this instance proves to be a significant theoretical construct in that it symbolises a move towards satisfying basic human needs in society. This occurs in the states incorporation of a ‘safety net’ in social policy which provides preventative measures that ensure no one in society would fall below and into impoverishment. Hence, this combined conceptualisation of ‘equality of opportunity’ and the ‘minimum floor’ idealisms represent a significant cornerstone in shaping the scope and ethos of the modern welfare state. In health service provision, the ideal of the minimum floor exists by way of preventing sickness and disease in society, while the concept of ‘equality of opportunity’ becomes apparent when the structures facilitate equitable access to baseline health care services. As such, the primary motivation in this instance is to protect a citizens ‘opportunity share’ to participate in all spheres of social and economic life (Daniels, 1985; Kymlicka, 2002; Rawls, 1971; see chapter 2, section, 2.3).

In applying Rawls conception of social justice to health care provision then, it is projected that for ‘equality of opportunity’ to be exercised to the fullest extent, the assumption that citizens are normal, fully functioning and with a complete life-span must be realised. Hence, the existence of a preventative health care institution is justified on the grounds of upholding and adapting this vision of equality. Furthermore, it is also articulated that for the general populace to successfully participate in the
political, social and economic life of society; a health care system featuring ‘equity of access’ serves as a paramount cornerstone to the realisation of Rawls theory (Daniels, 1985; chapter 2, section, 2.3).

With regards to the practicability, this study has found that Rawls theory of social justice is somewhat limited. The central reason for this is due to the theory itself being primarily directed at addressing the needs of those in the lower income stratum of society or those of which have the worse health status. Empirically, this comes to be symbolised in the operation of the GMS medical card for the lower socio-economic groups in society. This contrasts greatly to an outright egalitarian vision such as Sen’s theory of equality of outcome/capability which in application to health care provision would deem to achieve equality in health status across all citizens in society (Sen, 1992; Smith, 2009; see chapter 2, section 2.3 and 2.5).

The focal point of Sen’s theorisation in many respects goes much further than Rawls idealism of granting ‘fair’ equality of opportunity through access to social goods such as health and education. From this stance, Sen posited a critical glance at the ‘real’ opportunities available to individuals and what is ‘managed’ to be accomplished from that process. By contrast to Rawls theorisation, it is evident within Sen’s conceptualisation of equality that the ‘diversity’ of human beings (rich and poor, privileged and underprivileged) is taken into consideration as a determinant impacting on the achievement of a lasting equality in society. This theoretical viewpoint came to be articulated in the interview findings where it was highlighted that a central flaw of the ‘fair’ equality of opportunity principle is that it does not substantially eradicate inequality in society. In reference to health care, this is reflected in the operation of the GP visit only medical card where it was highlighted that while individuals in the middle-income stratum in society experience a degree of equality through being granted access to primary health care services. The equality instilled becomes redundant when an individual does not possess sufficient resources to purchase the prescribed medicine. Hence, this justifies Sen’s reasoning for an emphasis on ‘well-being’ and the ‘freedom to pursue well-being’ (interview findings; see chapter 5, section 5.5).

In part this diverts attention away from a sole focus on the instruments to achieve well-being (within Rawls conception) to a much wider scoped focus on an individual’s
capability to function. Within this conceptualisation, it can be argued that Sen’s theoretical framework of equality in many ways would be symbolised through the introduction of a universal health care structure. As such, a universal health care system would facilitate access to health care services in an inclusive manner for all citizens in society. Thus, this would enable a linkage to emerge between the availability of ‘real’ opportunities to what is ‘managed’ to be achieved in terms of well-being. However, it is evident that during critical moments in the Irish health care systems evolution both policy actors and vested interests have been consistent in resisting attempts to strike down the libertarian and willingness to pay principles embedded in the Irish health care structure. To a significant extent, this is reflective of what equality of condition theorists depict as a strong will to maintain the existing unequal hierarchy of wealth, income and power in society (Baker et al., 2004; chapter 2, section, 2.3 and see chapter 5, section 5.5).

The libertarian principles in this regard comes to be reflected when putting into context the large proportion of the Irish population who have to pay for GP primary care services in conjunction with secondary acute hospital care services (Social Justice Ireland, 2015; see chapter 1, section 1.1). Thus, it can be articulated that the ‘mixed motives’ system which developed effectively impeded the instilment, through a universal system of health care provision, of an outright vision of equality which treats patients on the basis of medical need rather than ability to pay.

6.3.2 Assessing the chronological evolution of the Irish health care system in terms of equality.

Within a chronological and empirical context, the ideals of medical treatment being delivered according to the contrasting premises of medical need and ability to pay have raised some significant findings, in both contextual literature and interview findings. Historically pre-1970, with the exception of the Poor Laws era, health care provision evolved with an aim to ensure social inclusion through providing health care on the basis of medical need to lower socio-economic groups such as members of the travelling community and the homeless. In conjunction with the development of the Irish health service and in accordance with Rawlsian conception of social justice and equality of
opportunity, a libertarian ethos has also remained to be a consistent underlying principle. As such, this study has found that the precept of willingness to pay has remained a dominant characteristic through the embedment of private medical practice with the passing of successive health care reforms. Below, it is critiqued through the critical junctures reviewed in this study how this framework in health service delivery came to be embedded.

6.3.3 Foundations of the libertarian and Rawlsian framework in social provision.

By comparison to the latter critical junctures reviewed, the *Irish Poor Laws* period proved to be significant in embedding a libertarian vision regarding social provision. This grew in response to the background sentiment in society during this period which was dictated by the ideals of classical liberalism and *laissez-faire* capitalism. As such, there was an evident libertarian ethos of non-state intervention and the upholding of principled idealisms such as: ‘individualism’; ‘self-help’; and the significance of ‘social networks and mutual supports’ within the family and community structures. This formed part of a cultural backdrop which viewed state intervention – by means of social provision – as an act of distorting the market place and contrary to *laissez-faire* ideological thinking (Clarke et al., 1987; Thane, 1996; Taylor, 1972; see chapter 4, section 4.2). Therefore, due to the significance placed on the libertarian idealism of the ‘free individual’ (who is charged with shaping his own life-course) equality did not feature as a predominant concern during this period.

Despite the largely dominant libertarian ethos, this study has found that Rawls theory of social justice can be traced, in an embryonic manner, through the establishment of the workhouse system. This early form of state intervention was characteristic of establishing a ‘minimum floor’ in which no individual was let fall beneath in respect to impoverishment (Burke, 1987; Brundage, 2002; Fraser, 1984; see chapter 4, section 4.2). By institutional design however, the ethos of equality remained to be largely absent due to the existence of policy precepts such as ‘deserving’ and ‘undeserving’ poor as a determinant of access to publicly funded social provision.

In egalitarian terms, the establishment of the *dispensary system, 1851* was symbolic in elevating a Rawlsian conception of social justice and containing the
invigorating forces of libertarianism in respect to social provision. From the increased state intervention which emanated from this period, Rawls conception of social justice and the principle of ‘fair’ equality of opportunity was consistent with the operation of the ‘relief ticket’ system. As such, the central objective was not to achieve a ‘redistributive’ vision of equality, but rather to explicitly target the health care needs of the lower-socio economic groups in society with the worst health status. Therefore, the eligibility of entitlement criterion, through the relief ticket system, characterises the dispensary system as an early form of ‘public’ health care provision designed for the lower income stratum in society and those in most need of health care services (Geary, 2004, Cox, 2010, Barrington, 1987; see chapter 4, section 4.3).

Notwithstanding, the dispensary systems elevation of the ‘minimum floor’ idealism in social provision, the ethos of libertarianism remained to be a dominant feature through the operation of private medicine. This is exemplified in the treatment of non-fee paying versus fee paying patients during this period. Fee paying patients were depicted as being ‘respectable’ members of society worthy of being treated in a Doctors surgery (usually a doctor’s home) away from the perceived infectious poor classes. Hence, the arising distinction between the classes of public and private patient suggests that the achievement of ‘outright’ equality was not at the forefront at this juncture in the Irish health care system’s development. Rather the primary motivation was to provide a preventative measure against sickness and disease through the delivery of basic health care services within an infrastructural network of public dispensaries (Barrington, 1987; Cox, 2010; chapter 4, section 4.3).

6.3.4 The predominance of the Rawlsian and Libertarian frameworks: assessing the rejection of equality through the prism of Universal Health Care.

From the contextual literature reviewed, it is evident that the debate surrounding the introduction of social/universal insurance was not absent in the Irish case. As during two central moments in the evolution of social provision, the National Health Insurance Act, 1911 and the Mother and Child Scheme, 1947, the object of modelling health care provision in accordance with these principles was effectively defeated. With regards to the National Health Insurance Act, 1911, the social insurance idealisms espoused during
this period represented a solid egalitarian foundation in that the state and citizens come together in a ‘collective’ manner to prevent destitution. This occurs through the policy instruments of social insurance contributions and the process of taxation. Therefore, the National Health Insurance Act, 1911 represented an extension of citizenship rights and duties which binds the state and its citizenry (Briggs, 2006; see chapter 4, section 4.4). However, the status quo established through the dispensary system was sustained and the pattern of inequality in the Irish health care sector in respect to the differential treatment between public and private patients was illuminated further.

In the second instance, had the Mother and Child Scheme been implemented in accordance with the principle ideals of the then Minister for Health Noel Browne, this would have undoubtedly marked a shift in health care provision towards a staunchly egalitarian ethos. Essentially, the universal manner in which free health care would have been provided to all the nations’ mothers and children up till the age of sixteen years suggests an attempt to drive Irish health care policy down a trajectory reflective of Sen’s theory of achieving equality in health care status across all individuals in society. This ‘universal’ approach to health care reform was reflective of the wider changes occurring in welfare state development across Europe during this period. In particular, the British state enacted a crusade of social reform measures aimed at creating a comprehensive and universal welfare state based on the ideal of shared citizenship (Pierson, 2006; see chapter 4, section 4.5). This came to be reflected in particular through the Beverigerian social reform agenda, through the establishment of the NHS amongst a wide range of social reforms. From the outset, these reform measures in social provision represented a ‘sustained attempt to reduce inequality through public action’ (Gamble, 1987; Alcock et al., 2004; see chapter 4, section 4.5). Therefore, health care provision in the United Kingdom through the NHS came to be firmly founded on the premise of ‘equal access for equal need’ (Smith, 2009; see chapter 4, section 4.5).

However, in the Irish case the ‘universal’ element present in the Mother and Child Scheme clashed with the conservative Catholic moral and social idealisms of ‘self-help’ and ‘non-state intervention’. In addition, it also conflicted with the medical profession’s desire to maintain the libertarian principles of private practice. Hence, the concept of ‘universal’ provision was firmly rejected and with it the ethos of ‘equal
access for equal need' for the entire population. As such, the primary emphasis was on
the further embedment of the conceptual ideal of *ability to pay* in the Irish health care
sector. This is particularly significant when analysing the development of ‘means-
testing’ and the ‘private health insurance’ in health care provision (see chapter 4, section
4.5 and 4.6).

Hence, the study findings reveal that since the establishment of the dispensary
system, public policy has been consistent in reflecting a Rawlsian egalitarian approach
to health care provision. In this regard, the enactment of the Health Act, 1953, which
contained a second attempt at introducing public health care provision for mothers and
children, included in the legislation the concept of ‘means testing’ and ‘eligibility of
entitlement’ as a determinant to accessing public health care provision (see chapter 4,
section 4.5). In egalitarian terms, this is very much consistent with a Rawlsian
conception of distributing health care in accordance with the needs of individuals with
the worse health status – those in the lower income stratum of society (Smith, 2009; see
chapter 2, section 2.5). Furthermore, this also reflects the sentiment of equality of
opportunity whereby the primary object is to ensure that individuals remain active
participants in the economic, political and social spheres. Therefore, the structure of
health care in this sense assures that individuals can become normal, fully functioning,
with a complete life-span and enabled to engage in these spheres (Daniels, 1985; see
chapter 2, section 2.3).

In terms of the libertarian and individualist idealisms present in the Irish health
care system, with the emerging distinction between ‘public’ and ‘private’ patients
through the establishment of eligibility of entitlement, this led to a proportion of the
population to be deemed un-eligible for public health care coverage. As such, the
establishment of the Voluntary Health Insurance (VHI), 1957 as a market based solution
symbolised the formal codification of distributing health care according to the premise
of *willingness to pay* through out-of-pocket payments for insurance premiums. Hence,
the VHI represents a significant cornerstone as not only did it rule out universal health
care coverage as a foreseeable policy option; it also affirmed the status quo through, in
legislative terms, demarcating between ‘public’ and ‘private’ patients (see chapter 4,
section 4.6 and chapter 5, section 5.7). Moreover, this juncture in health care reform also
symbolised the formal coming into existence of the ‘mixed motives’ structure. In egalitarian terms, the implications of this structuration highlight that Sen’s theoretical vision of equality of outcome/capability becomes unworkable due to the health care system not being organised in a manner conducive towards the achievement of equality in health care status across all individuals in society irrespective of socio-economic class.

6.3.5 Post 1970 – Assessing the instilment of equality in the contemporary health care arena.

In contemporary times, it is evident that the critical junctures surrounding the establishment of the health boards and the HSE were significant for reasons associated with the delivery of efficiencies rather than philosophical interpretations on the egalitarian ethos of the Irish health care system moving forward. As such, the continuity of the ‘mixed motives’ system rather than change proved to be a central precursor in shaping contemporary health care reforms. This was apparent in the further codification, through the Health Act, 1970, of the eligibility of entitlement and means-testing policy constructs that were cultivated in previous critical junctures (see chapter 4, section, 4.7).

While not present in an outright or ‘explicit’ fashion, the status of equality has nonetheless been derived in the interview findings to exist in an ‘implicit’ form within the structuration of the health care system. In this sense, it is apparent that the principle of ‘efficiency’ – in the administrative delivery of the health services – was deemed to be a central prerequisite to enabling equality to prevail. This highlights that what can be achieved in a ‘practical’ sense formed a significant determinant to the level of equality which could be instilled in service delivery. Hence, the achievement of ‘outright’ equality was not perceived to be a ‘pragmatic’ course of action due to a perception held that it would lead to a collapse in the efficient administration of health service delivery (see chapter, 5, section 5.9).

Within this framework, it can be articulated from the interview findings that the coming into existence of the GMS medical card is symbolic of a Rawlsian conceptualisation of social justice in that the primary motive was to distribute health care to those individuals with the worst health care status and with limited economic
means. As such, the GMS medical card and by extension the universal public nursing for new mothers operating in the primary health care sector in many respects mirror the egalitarian ethos of ‘equality of opportunity’ (Daniels, 1985; see chapter 2, section 2.3 and chapter 5, section 5.6). This is due to the fact that by institutional design, their purpose is to alleviate discriminative barriers in the availing of health care provision. Additionally, it also ensures that individuals from the lower income stratum/most vulnerable in society have access to basic forms of health care provision and are thus protected in times of illness.

This vision of equality is reflective of being ‘purposeful’ or ‘targeted’ rather than ‘universal’ in ethos as the primary intention is to focus exclusively on the lower-socio economic groups in society or those deemed to be in most need of medical care. As such, it can be interpreted that the policy construct of eligibility acts as an instrument to illuminate those sections of the population which require protection. Furthermore, it implies a ‘looking after’ function whereby through the mechanism of the ‘poverty net’, the state actively intervenes with public health care provision when an individual is no longer able to fend for themselves or family members. Thus, the Health Act, 1970 critical juncture can be depicted as being a ‘pro-poor’ measure rather than an attempt to introduce universal entitlement or eradicate the inequalities inherent in the institutional fabric of a ‘mixed-motives’ health care system (see chapter 5, section 5.6)

However, this conceptualisation of equality has been depicted as possessing a limitation factor in terms of the impact which the Health Act, 1970 and the policy instrument of eligibility of entitlement to public access had on creating an egalitarian ethos in the delivery of health care services. This is due to the concept of ‘eligibility’ of entitlement not lending itself to the creation of a ‘legally enforceable right to health care’ in a universal sense (see chapter 5, section 5.9). On the contrary, the interview findings stipulate that within the Irish health care systems structuration, an ‘internal’ form of equality exists in respect to specific income categories. In practice, this ideal comes to fruition when observing the operation of the GMS medical card as a form of public provision that is available to the lower income group/most vulnerable in society. Essentially, it is perceived that the internal ideal of equality is realised when those within the lower income category experience the same level of access to public health
care services – such as free GP care etc. External to this income category however, equality becomes prohibited due to the fact that the middle-upper income groups do not experience the same level of access due to the policy instrument of eligibility (see chapter 5, section 5.5). Therefore, the codification of the eligibility of entitlement criterion through the Health Act, 1970 has served to circumvent the creation of an outright egalitarian ethos in Irish health care provision.

Nonetheless, by comparison to earlier junctures it is evident that the enactment of the Health Act, 1970 has elevated a sentiment of equality somewhat through the ‘choice of doctor’ element in the reform process. As revealed in the study findings, the introduction of the ‘choice of doctor’ system enabled the removal of discriminative barriers in respect to the treatment of fee and non-fee paying patients. However, the choice of doctor system was depicted as an instrument designed to facilitate ‘social improvement’ in society than an attempt to elevate equality. Furthermore, in efficiency terms it was also symptomatic of a process designed to instil social harmony in society and reduce the propensity for social conflict between social classes (Hensey, 1988; Barrington, 1987; see chapter 4, section 4.7 and chapter 5, section 5.9). Hence, the status quo, which contained the parallel system of ‘public’ and ‘private’ patient access, continued to be antecedent feature of the institutional fabric of the Irish health care system. This in turn highlights that the incorporation of the principled ethos equal treatment for equal need does not feature as a predominant motivation due to the fact that patients remain to be distinguished on the basis of a libertarian conception of ability to pay in availing of health care services.

6.3.6 Conceptualising equality in contemporary times: the emergence of ‘equity’ in the Irish health care arena.

In a similar fashion to the previous critical juncture, the Health Act, 2004 emphasised on modernising the governance model which oversaw the implementation of health care services throughout the country. Notwithstanding the predominant philosophy of efficiency in existence, in the lead up to the establishment of the HSE there were some interesting developments in relation to the principle of equality being replaced by an
alternating concept of a different meaning, equity. These developments played a crucial role in shaping the operational practices of the HSE agency.

Equality in a general sense has been conceptualised in the study findings as a term that encompasses elements of ‘redistribution’ in terms of material resources (such as income) as well as the ‘availability of resources’ (such as health care, education and social goods generally) amongst all social groups in society (Baker et al., 2004; see chapter 2, section 2.3). In health care, equality has been depicted in the study findings as a concept which focuses on the eradicating of inequality in health status between individuals and groups. By comparison, the concept of equity emphasises on the distribution of resources that drive a particular inequality between groups in an unfair or unjust manner. Therefore, the principle of equity derived in the study findings implies a process of bringing about ‘fairness’ and/or ‘social justice’ in the distribution of health care. This can occur through a policy emphasis vertical equity (e.g. providing health care to those who are the same in respect to needs) and/or horizontal equity (e.g. the individual with the greater need for health care will receive more treatment than an individual with a lower need for health care) (Braveman and Gruskin, 2003; Chang, 2002; Smith, 2009; Duclos, 2006; see chapter 2, section 2.4).

The principle of equity was reflected in the interview findings as a somewhat watered down vision of equality. As such, the primary aim was not to seek redistribution and equality in health across all individuals but rather to achieve what is ‘fair’ and ‘just’ amongst social groups in society (see chapter 5, section 5.5). This is consistent with the literature findings, where equity in health care is defined as a process of ensuring that everyone has the opportunity to attain their full health potential and not be disadvantaged from achieving this potential (Whitehead, 1990; see chapter 2, section 2.4).

Under this conceptualisation of equity then, a justification is provided for the maintaining of policy instruments such as ‘eligibility of entitlement’ and ‘means-testing’. As such, the existence of the GMS medical card in this instance correlates with the principle of equity in that the central objective is to enable a ‘fair’ distribution of health care throughout the country. This is to ensure that those who cannot afford health care have the opportunity to reach their health care potential (see chapter 5, section 5.5).
Furthermore, it also affirms that no discriminatory barriers are in place that would impinge on the ability of individuals in the lower income groups to receive health care. However, as a whole this framework does not serve to eradicate the two-tiered system of access and the public-private mix in health care provision. Hence, this correlates with what Chang (2002) described as the lack of agreement surrounding what inequalities are unnecessary, avoidable, unfair and ultimately inequitable (see chapter 2, section 2.4).

As such, the interview findings indicate that a further limitation of equity, as a principle, relates to the fact that policy actors in a general sense do no set out with the clear objective of achieving outright equality in service provision. On the contrary, the provision of universal entitlement/equal access to health care provision is perceived to be unjustified. The central reason for this rests on a perception that a prevailing public sentiment exists which is adverse to universal entitlement in health care provision. This is based on a common public belief that demonstrating ‘ability to pay’ leads to swifter access to health care above those who ‘cannot afford to pay’ (see chapter 5, section 5.5). Therefore, the ideal of achieving ‘outright equality’ has become a secondary concern to the attainment of ‘equity’ and ‘fairness’ in health service delivery. By implication, this symbolically demonstrates that the principle of access to medical treatment according to the precept of ability to pay effectively supersedes the premise of universal access on the basis of medical need.

6.3.7 Assessing the operational practice of equality in the contemporary health care system.

Despite the various egalitarian interpretations applied to the Irish health care system, it is prevalent in a definitional sense that no national stance exists on what equality embodies in public policy. The lack of clarity and consistency in deriving an operational definition becomes more prevalent when analysing the implications of the Quality and Fairness: A health service for you (2001) report. Generally, the report was primarily concerned with the ideals of ‘equity’ and ‘fairness’ in access to health care provision. However, the study findings have uncovered that the content of this report expands much further than issues pertaining solely to equity and fairness (see chapter 5, section 5.5).
As such, the report has been described as a blueprint outlining a modernisation programme that would instrumentally bring the Irish health care system into the 21st century. Furthermore, the report was also consistent with the theoretical meaning of equity discussed above in terms of its objectives which is to instil in health service delivery a ‘spirit of fairness’ as oppose to ‘universal entitlement’ regarding all income groups. As such, the study findings reveal that the primary aim of policy actors in contemporary times was to ensure that those who experience specific health care conditions and the lower income groups are afforded with health care provision. While those in the higher income strata in society continue to fend for themselves. Furthermore, the theoretical framework of equity (particularly in terms of horizontal and vertical equity) provides a justification for the prioritisation and ring-fencing of fiscal resources in areas such as cardiovascular services and breast cancer screening by contrast to the less serious ailments in health care services. While this is contrary to an outright egalitarian vision, the ‘spirit of fairness’ nonetheless provides an assurance that those in the most dire need (such as cancer and cardiovascular issues) are prioritised over patients with less serious conditions (see chapter 5, section 5.5).

The study findings also articulate that the transformative changes to emerge following the publication of the *Quality and Fairness* report symbolised the effective elevation of the ‘public sector’ as distinct from the ‘private sector’ in health service provision. This represents a positive transformation in an egalitarian sense in that it leads to the development of a ‘standards and population health’ based approach to the provision of specialist health care treatment inclusive of the entire Irish population. Empirically, the predominance of the public hospital system’s elevation is evident in the establishment of *Centres of Excellence* to tackle the ‘three big killers’ impacting on the health of Irish people in a modern context: heart disease; cancer; and accidents. The emphasis on developing a strong public health care structure grew out of a realisation that the private sector, with its disaggregated configuration throughout the country, no longer held the capacity to provide a proficient level of quality patient care. Therefore, in contemporary times, the shift towards centralised units in health service delivery reflects an endeavour towards achieving a *quality driven* health care service and by extension improved patient outcomes to be experienced by the entire Irish population.
(see chapter 5, section 5.5 and 5.6). This is consistent with the literature findings on the theoretical framework of ‘equity’ in that one of the core principles is to deliver the same level of high standard professional care to all sections of the community (Whitehead, 1990; see chapter 2, section 2.4).

In terms of policy implementation, the establishment of the HSE, through the Health Act, 2004, was viewed as a central vehicle in delivering health care services to the Irish population in a fair and equitable manner. From the outset, the HSE has been depicted as being instrumental in advancing principles of governance, management and accountability in service delivery. Hence, as the interview findings deduce, the Health Act, 2004 “didn’t really change anything in terms of the ordinary person going to the doctor or needing hospital care. It just changed the structures that oversaw those services. So in a way it had nothing to do with equality”. However, it can be argued that the HSE, through the standardisation of services, has facilitated geographical equality regarding service delivery throughout the country (see chapter 5, section 5.10).

From this standpoint, the primary emphasis in recent decades has been on advancing the quality of standards and effectiveness in patient care through the infrastructural base of the public hospital system. While, in a paternalistic fashion, issues of access and extension of equality was envisaged through the provision of baseline health care services to those in lower socio-economic classes was pertinent in the 1970’s, the noughties demonstrated a fundamental shift in thinking. In that, as the interview findings clarify, the granting of ‘access’ was no longer seen as a proficient goal in health care policy. On the contrary, a broader ideal of equality is now being envisaged through the attainment of positive patient outcomes and advancement in the health status of the Irish citizenry (see chapter 5, section 5.10).

6.3.8 Inequality and the perceived discrimination associated with ‘eligibility of entitlement’ and ‘incentivising of the private sector’.

Despite pronouncements of equity and the instilment of fairness to emerge in the policy discourse, inequality and discriminatory practices regarding access and entitlement still remain to be a consistent feature characterising contemporary health care provision. In this regard, the study findings cite the policy instrument of ‘eligibility of entitlement’
and the ‘incentivising of the private sector’ as the primary source of inequity in the Irish health care system.

Since the Poor Laws era and its associated ideals of deserving and undeserving poor, there has been a clear policy trajectory which effectively demarcated patients on the basis of income and ability to pay. As such, these inherited ideals informed the coming into existence of ‘public’ and ‘private’ patient status differentials. On the part of the public patient, the interview findings denote that the ‘label’ attached to this category of patient has led to a negative connotation in respect to constraining access to specialist diagnostic treatment and acute public hospital services. While for private patients, demonstrating ability to pay led to swifter access (through the practice of queue jumping with a system two-tier access) to the same services. Thus, the only equality which exists in this regard is the ‘pain’ that derives from having a similar health care condition (see chapter 5, section 5.7).

The existence of discrimination regarding access becomes elevated further when contextualising the experiences of the perceived ‘copping classes’ in society. A patient category that consists of middle-income individuals who are without health care coverage due to being ineligible for public provision and cannot afford private health insurance. Therefore, from the study findings it is generally acknowledged that the demarcation of ‘public’ and ‘private’ patients through ‘eligibility of entitlement’ has served to entrench inefficiency and inequity in service delivery (see chapter 5, section 5.7).

The discriminative practices associated with demarcating patients on the basis of ability to pay and the existence of the public-private mix has been depicted in the study findings as arising from the incentivising of the private sector in health care provision. As such, the increased utilisation of the private sector acted as a mechanism to provide a secure line of funding in the Irish health care system. Hence, dependence on the private sector has encouraged middle-upper income groups to by-pass the public hospital system and purchase private health insurance in meeting their health care needs. As a consequence, this institutionalised further the demarcation lines between ‘public’ and ‘private’ patients and with it the discriminative practice of ‘queue-jumping’ and ‘two-tier access’ to health service provision. The interview findings stipulate that a possible
solution to this problem would be to introduce a ‘Health Status Act’. While this act would by design eradicate the discrimination of public patients in favour of private patients, the source of inequality in the Irish health care system: the public-private mix in service delivery would remain intact (see chapter 5, section 5.7).

To surmise, it can be articulated that the co-existence of ‘eligibility of entitlement’ in tandem with ‘incentivising the private sector’ has served to reinforce the principle of ‘ability to pay’ in health service delivery above the precept of receiving medical treatment on the ‘basis of need’.

6.3.9 Objective One: Summary of the main findings.

From the study findings on the conceptual framework of equality, it is evident that the Irish health care system encompasses both a Rawlsian conception of social justice (fair equality of opportunity) and a Libertarian ethos in respect to service delivery. This ‘mixed motives’ approach has led to a limited form of equality emerging in the structuration of health service provision to the Irish populace. As such, through reviewing the evolution of equality, it is evident that the ethos envisaged was one which primarily focused on ensuring that the least well off or the most vulnerable in society received health care provision. Therefore, the policy construct of eligibility of entitlement (GMS medical Card) has been highlighted to represent a ‘purposeful’ or ‘targeted’ vision of equality. This is reflective of a Rawlsian conception of social justice in that it serves to provide a baseline of impoverishment which no citizen in society would fall beneath. This vision of equality is extended further through the focus of policy actors on equity and the instilment of fairness in health service delivery. In this context, the findings highlight that the primary emphasis in this instance is on giving people what ‘they deserve’ rather than what ‘they need’ by way of health care services. This would be in contrast to an outright egalitarian measure, such as Sen’s equality of outcome/capability framework, which seeks to provide equality of access (e.g. universal health care) to all citizens in society irrespective of income. Therefore, the existence ‘eligibility of entitlement’ in tandem with libertarian principles such as the health insurance and the public-private mix has served to exasperate inequality and discriminative practices in health service provision. Furthermore, the mixed-motives
system has reinforced the principle of delivering health care in accordance with ability to pay rather than on the basis of medical need.

6.4 In analysing the legislative enactments of the Health Acts, 1970 and 2004, what evidence is there to suggest that ‘efficiency’ in the governance structure formed a principled tenet during these periods?

In contemporary times, the Health Acts, 1970 and 2004 have left an indelible imprint on the administrative landscape of the Irish health care system. Retrospectively, these enactments emerged in response to growing advancements in modern medicine and increasing complexities associated with new and existing health problems to impinge on the Irish population. At the core of this legislative transformation has been the upholding of a principled stance on efficiency to ensure, through the process of governance reform, optimal outcomes in the delivery of health care services across the Irish state. This study has found that by comparison to establishing a philosophical ethos of equality, the embedment of efficiency principles have proven to be a much more pressing concern in the policy sphere. In this sense, it is stipulated that without efficiency in the governance structure, the achievement of equality becomes impossible. Thus, in this section, the primary emphasis will be on these two crucial legislative enactments which formed a central cornerstone in how the health services came to be delivered in recent times. This section shall also examine the principles of efficiency which have governed the Irish health system in the past four decades and how they have contributed to the advancement of service delivery.

6.4.1 Health Act, 1970: Assessing its impact on the institutional landscape of service delivery.

The Health Act, 1970 and the context in which this piece of legislation came to fruition has been recounted as being the product of a ‘period of scrutiny’ over the administrative practice and the manner in which the Irish health services was organised. It was also a period of deep uncertainty and change due to the discovery of new medical advancements in tandem with emerging health care problems coming to the fore. Therefore, the complexity to emerge from this period of change proved to be a central
precursor (along with increasing fiscal demands to fund health care services) to introducing for its time an innovative governance structure health care administration (Hensey, 1988; Barrington, 1987; chapter 4, section 4.7). The primary stimulus behind the enactment of the Health Act, 1970 was a structural one. Hence, this legislative enactment came to symbolise an embryonic attempt by government through the health boards configuration to devise a coordinated and regionalised approach to the development of health policy in Ireland (see chapter 5, section 5.9).

At the core of this legislative and modernisation period was the achievement of efficiency as a principled aim. This came to be demonstrated through the publication of the Select Committee on the Health Services, the 1966 White Paper and the Fitzgerald Report, 1967, each of which were sent a clear mandate by government to deliberate on matters of structural reform in the Irish health services. As such, this represented a foundational attempt by government to rationalise the Irish health service from a localised county structure to a regionalised administrative system. Central to this process was a desire to achieve efficiencies through strengthening the infrastructural base – rationalisation of the hospital system – of health service delivery on a regional capacity. Therefore, the primary motivation of this legislative agenda was to provide a modernised form of acute hospital care through having fewer hospitals but with an elevated emphasis on patient safety, economic performance and medical and nurse training. Within this framework then, the reconstruction of the networked hospital system demonstrates that the principle of efficiency was a predominant concern during this period (Barrington, 1987; Hensey, 1988; see chapter 4, section 4.7 and chapter 5, section 5.9).

6.4.2 Governance reform and the rise of New Public Management: addressing administrative legacies from the past.

The creation of the Health Service Executive (HSE) agency, which formed a central cornerstone to the enactment of the Health Act, 2004, marked another crucial point in the evolution of the Irish health care system in efficiency terms. As such, this legislative enactment reflected both a trajectory of continuity and modernisation in the evolution of the Irish health care system. However, at the core of this process was the desire to
achieve increased efficiency and accountability through correcting the administrative ills which transcended from the Health Act, 1970 and the health boards established therein.

In underpinning the principle of efficiency theoretically in the Irish health care system, it is evident that the orthodoxy of New Public Management (NPM) proved to be pivotal in this context. Central to this theoretical core of public administration was reorienting the traditional meanings of government towards a modern conception of ‘governance’. As such, this essentially stipulates the State’s consideration of alternative sources of governance in the active provision of social services. One of the primary emphases within the modern guise of ‘managerialism’ was to apply private sector techniques to public sector operations and in the process generate efficiencies through controlling fiscal spending and disaggregating the size of the public bureaucracy. Therefore, the principle of efficiency comes to fruition through reconfiguring the management efforts of public sector organisations from a focus on ‘inputs’ to ‘outputs’ in respect to policy outcomes. Also within this framework, the NPM perspective marked a clear shift in administrative practice towards strategizing, performance measurement and standards (Hood, 1991; Rhodes, 1996; Pollitt, 2001; see chapter 2, section 2.6).

From the Irish perspective, the managerial ethos of the NPM came to be practiced through the implementation of the Strategic Management Initiative (SMI). As such, the primary impetus of this administrative framework focused on the ideals of strategic planning, provision of quality services to customer/citizens and making effective use of state resources (MacCartaigh, 2008; OECD, 2008; Collins, 2007; see chapter 2, section 2.6). In the context of the Irish health care system, it is evident that the management tools of the NPM/SMI came to be reflected in the strategy statements published by the Department of Health in that a clear linkage has been established between the ‘fiscal resources’ available and the ‘strategic objectives’ of the organisation moving forward. Hence, there is evidence to suggest that strategy statements published post-SMI have offered a useful accountability tool for the political sphere in the management of health care services (Byers, 2009; see chapter 2, section 2.6). In particular, the Quality and Fairness: A health care system for you report, 2001 proved to be significant in extending further the principles enshrined in the NPM/SMI in that it outlined succinctly the strategic objective of the organisation for the subsequent ten
years following its publication. Furthermore, it also provided concise principles to support its strategic objectives such as ‘equity and fairness’, ‘a people centred service’, ‘quality of care’ and ‘clear accountability’ (Byers, 2009; DOHC, 2001; see chapter 2, section 2.6).

Therefore, the Quality and Fairness strategy represented an important cornerstone in the reform of the Irish health services in recent times. Not only did it invoke the efficient governance methods of the NPM/SMI, it also provided the stimulus for subsequent reforms following its publication. One of the most notable reforms to arise in this context was the enactment of the Health Act, 2004 which led to the creation of the autonomous HSE agency. As an organisational entity, the HSE incorporated much of the principles enshrined in the orthodoxy of NPM. As such, it is clear that the contemporary reform facilitated the ‘steering’ and ‘rowing’ analogy which generated efficiency through creating a clear division between the actions of policy ‘making’ – the remit of the Department of Health – and ‘implementation’ – the remit of the HSE agency. Furthermore, in the process of disaggregating hierarchal patterns in public sector governance this also formed part introducing private sector techniques, such as ‘hands-on-professional management’, in the efficient execution of policy (Hood 1991; Rhodes, 1996; see chapter 2, section 2.6).

Hence, the instilment of NPM efficiency principles on the governance structure of the Irish health care system proved to be the dominant force behind this era legislative reform. As such, the practical issues which manifested from the health boards organisational structure such as: political localism; inefficiencies and incoherence in the initiation and implementation of health policy at a national level; and the geographical inequalities to emerge in respect to both access and availability of health care services; provided the stimulus for introducing a modernised system of governance in the health care arena at a national level (see chapter 5, section 5.10). Additionally, there was a realisation that the health boards structure of governance in contemporary times impeded the ability of government to both initiate and execute health policy. Furthermore, due to the dispersive institutional architecture of the health boards structure, public administration concepts such as ‘good governance’ and ‘efficiency’ became increasingly redundant (see 5, section 5.10).
As such, the transition from a ‘regionalised’ to a ‘centralised’ governance structure proved to be a significant development during this period. Thus, the establishment of the HSE in this instance represented an attempt to enhance fiscal control with respect to both the execution of health care policy and the administration of health care services throughout the country. One of the central reasons for this transition was due to the fact that ‘fragmented governance’ was becoming increasingly synonymous with the health board structure. This was reflected in the incapacity of the health boards to standardise the scope and level of health care on a national basis. Furthermore, the intrusion by local community groups and public representatives as vested interests at a localised level also prevented efficiencies from coming to fruition within this framework (see 5, section 5.10).

The disbandment of the health boards’ structure has been depicted in the study findings as forming part of a drive by policy actors to instil similar yet interchangeable theoretical concepts of: efficiency; standardisation; consistency; and coherence in the delivery of health care services. Therefore, it is prevalent that the principle of ‘efficiency’ derived in both a theoretical and practical sense at this juncture of reform, correlated with the theoretical principles established in the NPM (see chapter 2, section 2.6 and chapter 5, section 5.10). Additionally, the objective of achieving effective governance was also believed to exist simultaneously with the ideal of achieving geographical equality in the implementation of health policy. This formed part of a policy perception that when the principles of equality and efficiency operate in tandem, this effectively facilitates the provision of more extensive health care services. As such, with the increased efficiencies to emanate from having a centralised governance structure, this is thought to facilitate resourceful budgeting and an enhanced capacity to fund services. Hence, the study findings project with the achievement of lasting efficiencies this can lead to equality through more extensive service provision (see 5, section 5.10).

From the above contextualisation of health care reform, the establishment of the HSE symbolised the dawning of a new era in which from the SMI, it drew on the concepts of ‘quality in service delivery’ and ‘efficiency in health care provision’. In combination, these concepts have taken centre stage as the dominant principles
influencing the Irish health care system moving forward. More fundamentally, the concept of a ‘population health’ approach which first came to fruition during the 1970’s was elevated further at this juncture of health care reform. As such, this formed the *raison d’être* for reconstructing the institutional structure of the Irish health care arena to reflect both ‘efficiency’ and ‘good governance’ in service delivery. This process was demonstrated further through the development of a policy focus on *quality, standards* and *data collection* (see 5, section 5.10). Furthermore, this connotation was also reflected by the OECD who stated that in the Irish case the approach to efficiency was emphasising increasingly on the complexities associated with providing specialist services to a dispersed population (OECD, 2008; see chapter 1, section 1.3.1).

### 6.4.3 HSE and the process of centralisation: A *coordinated and standardised approach to health care delivery.*

In terms identifying areas of increased efficiencies since the establishment of the HSE, the interview findings have recurred some of the central themes regarding advancements made in areas such as: patient outcomes; consistency; and coherence in service delivery through the centralisation process; and finally with the process of standardisation (ideal of having a ‘singular voice’ to negotiate on behalf of the entire organisation). Pivotal to this process of instilling efficiency as a whole was the coordinated and quality driven ethos which was perceived to be only achievable under the organisational façade of the HSE. Hence, it was depicted that the positive patient outcomes achieved in the areas of: cancer; cardiac; and acute medical care represent the end product of this coordinated and synchronised trajectory which the HSE has delivered since its inception (see chapter 5, section 5.10).

At a practical level, this conceptual ideal of a coordinated approach to service delivery has been highlighted in the study findings to be particularly evident regarding the establishment of the Centres of Excellence – most notably in the areas of cancer and cardiac care. The central reason for this rests on the fact that during the health boards era of administration, the rolling out of a standardised and centralised cancer care strategy would have been impossible. Primarily, this resonates with the fact that under the regionalised health board structure, the necessitated expertise and resources would have
to be spread out and duplicated across small hospital hubs across the country. By stark contrast, under the centralised model, a singular Centre of Excellence in each province of the country where all the ‘cancer expertise is’, provided an assurance that there would be measurable advancements in patient outcomes through clinical safety and the provision of clinical specialists (see chapter 5, section 5.10).

The consolidator properties of the HSE as a centralised and autonomous entity have also been deemed to facilitate efficiency in regard to the acquiring of information and the availability of data to policy actors in the health policy arena. As such, this proved to be significant in assuaging coherent patient outcomes throughout the country. Under the previous system, due to the regionalised stand-alone structure of the health board system, the data information differed greatly with regards to the collection process and the calculation methods utilised from one geographical area of the country to the next. Therefore, in this sense the principle of efficiency resonates in that the centralisation of the HSE facilitated collection of a standardised and consistent record of data information on patient outcomes and the services available throughout the country. However, despite this framework existing for the collection of data, the study findings has uncovered that more ‘real time’ information is required moving forward with the provision of a quality driven health care service (see chapter 5, section 5.10).

From this summation then, it is evident that the principle of efficiency delivered in a practical sense is consistent with the principles of the NPM-SMI orthodoxy. Through the objective aims in health service delivery of standardisation, coordination, consistency, coherence and delivering a quality driven service this affirms that the principle of efficiency was a predominant precursor in shaping this contemporary effort at health care reform. As such, it was through instilling these measures of ‘good governance’ that the ideals of NPM-SMI come to fruition in the Irish health services. In particular, the disaggregation of public services through the process of centralisation (e.g. Centres of Excellence and establishment of the HSE), complies with introducing a more lean system of specialised service delivery rather than in multi-purpose hierarchal structures. Furthermore, at this juncture of reform there was a clear emphasis on serving the customer (citizens and the government) primarily through reorienting the focus on ‘outputs’ rather than ‘inputs’ (Hood, 1996; Rhodes, 1996; Pollitt, 2001; MacCartaigh,
2008; see chapter 2, section 2.6). This is particularly pertinent when analysing the standardisation of data information in the determination of patient outcomes (see chapter 5, section 5.10).

6.4.4 Health Service Executive: Assessing present inefficiencies associated with contemporary health service provision.

From the outset, the Health Act, 2004 by design provided a framework in which efficiencies could be delivered in the advancement of patient outcomes and health service provision generally. However, the research findings on the performance of the HSE since its inception, has depicted that the organisation in its current functioning represents something of a ‘monstrous monolith doing very little for the health of the nation’. This formed part of a widely held perception that following the establishment of the HSE, the inefficiencies which emerged in service delivery far outweighed the efficiencies achieved in this period. As such, the inefficiencies were borne out of the swift pace at which the HSE was initially set up. Hence, a picture has emerged which portrays the institutional environment during this time as being influenced by the prevailing political ideological agendas of the day rather than implementing a theoretical approach to the achievement of efficient governance in health service delivery (see chapter 5, section 5.10).

6.4.5 Role of political and vested interests on the instilment of ‘efficient governance’.

The interview findings indicate that the inefficiency associated with the HSE from the outset originated from the intrusion of the political sphere and the vested interests (see chapter 5, section 5.10). As a consequence, this effectively impeded the adaption, to the fullest extent, of a process of rationalisation which according to the theory of NPM ought to have occurred in practice. The advantages of the rationalisation/disaggregation process, if implemented, would have facilitated the replacing of previous monolithic bureaucratic structures with more manageable units on an arms-length basis. Furthermore, the NPM principles in this context would have advanced efficiencies through being more flexible in respect to Human Resources and resisting Trade Union
demands. As such, this would have instilled a ‘do more with less’ ethos in public service (Hood, 1991; see chapter 2, section 2.6). However, in the Irish case, the contrary occurred in that the senior officials who were employed in each health board structure came to be subsumed into the centralised HSE structure and given what were described in the findings as ‘artificial jobs’. Hence, this inhibited the streamlined efficiencies which should have occurred from the abolition of the health boards (a largely duplicative model of administration). The study findings thus highlight that the rationalisation benefits from downsizing human resources did not occur in the Irish case.

In part, this was due to the swift pace in which the HSE was set up through the Go Live ’05 political campaign. The political aspirations of the day in this respect, has been recurred in the interview findings as being the root cause of the organisations long-term capacity to generate optimal efficiencies in service delivery (see chapter 5, section 5.10).

Furthermore, the absence of rationalisation has also been attributed to the negotiations between the political elite and the trade union vested interests (in this regard IMPACT and SIPTU) in the lead up to the transferral of executive powers to the HSE. This led to the development of what has been described as an overburdened bureaucracy lacking efficient structuration. Therefore, the achievement of optimal efficiencies was undermined by the expansion of management grades and an excessive managerial ethos which evolved following the creation of the HSE. As such, the inefficiency borne in this regard depicted a corporatist/managerial entity that had the effect of disempowering front line health care professionals (such as doctors and nurses). Consequently, this resulted in a loss of institutional knowledge within respective clinical areas (see chapter 5, section 5.10). From this standpoint, it can be assuaged that the inefficiencies amounted from the failure to ‘apply fully’ a theoretical framework of ‘efficient’ governance to the Irish health care system.

6.4.6 The practice of centralisation: does the centralised entity of the HSE reap optimal efficiencies in service delivery?

It is evident that there are some significant discrepancies between the theory of governance and what occurred in practice in respect to the HSE. However, when assessing the inefficiencies of policy outcomes in recent times, this has led to a
reassessment of the theoretical concept of centralisation which formed a central cornerstone to this reform initiative. Essentially, the interview findings indicate that with the loss of empowerment experienced by frontline staff in tandem with the loss of decision making power to the hierarchal chain of command of the HSE, the theory of centralisation has been depicted as an inhibitor to establishing streamlined efficiencies. Therefore, it can be derived that excessive centralisation and managerialism does not necessarily lead to the achievement of optimal efficiencies in the organisation of health service provision (see chapter 5, section 5.10).

While it is prevalent that the theoretical practice of centralisation proved to be significant in facilitating preventative and accountable practices with regards to the allocation of fiscal resources. The HSE has also facilitated, in the decision making process, a disconnect between those working in an administrative capacity and those which are in the health care professional remit. In this context, it is depicted that the centralisation of decision-making at the top of the organisational pyramid has led to an ignorance of what was occurring in clinical practice. Therefore, the theory of centralisation is perceived to be a root cause of inefficiency due to the decision-making process being far removed from what is occurring in regard to service delivery (see chapter 5, section 5.10).

From a structural and performance standpoint, the interview findings depicted that the existence of the silo’s system – which deals with specific areas of patient care – within the internal architecture of the HSE has raised issues of concern regarding the delivery of health care services in an efficient and equitable manner. In this context, the practice of inefficiency is traced through the perceived lack of policy coordination and connectedness between respective pillars of service delivery. Additionally, the differential silos model of patient care were deemed to be too rigid of a system in that it was insufficiently capable of addressing patient issues not contained within a distinctive pillar – for instance not accounting for overlap within the pillars of mental health and children’s health (see chapter 5, section 5.10). This in turn demonstrates that an ethos of excessive ‘efficiency’ (through the principles of ‘rationalisation’ and ‘centralisation’) can result in undesired and unequal outcomes in health care policy.
The theory of rationality and centralisation has also been called into question regarding its suitability to an organisation that encompasses a large scope of responsibilities in the delivery of social services to the Irish state. From the outset, the HSE proved to be extensively absorptive regarding the array of responsibilities that came under its remit. As such, it has been disputed in the interview findings that while there may have been an argument for establishing an agency to administer the acute aspects of hospital delivery; this was perceived to be unnecessary for the provision of non-acute illnesses to the population – such as disability services which could be provided at primary care level. Essentially, it is articulated that had the HSE a more scaled remit confined to acute and primary/community care, more efficiencies could have been derived in respect to patient outcomes and health care delivery generally (see chapter 5, section 5.10).

6.4.7 Assessing the power dynamics within the internal management structure: does the HSE deliver optimal efficiencies in administrative practice?

In terms of assessing the internal management structure of the HSE agency, it has been recounted in the interview findings that existing power dynamics form a source of inefficiency in respect to performance in service delivery. Upon the transferral of administrative power from the health boards structuration to the HSE, there has been a notable weakening of a managerial force in the organisation of health service delivery. In this regard, it was highlighted that under the health boards’ model, policy administrators held significantly more power. This was due to an alliance which existed between the political and management spheres which proved to be instrumental in efficiency terms. However, with the establishment of the HSE at ‘arms-length’ from its parent Department in tandem with the loss of political and vested interest power at local level under the health boards, this severed that alliance which once existed. As a consequence, this has led to the exponential growth in power of the medical profession which was once contained by the existence of the politico-administrative alliance under the health boards. Therefore, the study findings highlight that the shift in power dynamics within the internal structure of the health care system has had some bearing on the inefficiencies produced under the HSE configuration (see chapter 5, section 5.10).
At a localised level, it has been attributed that inefficiencies also occur in respect to hospital management. In this context, managerial efficiency at local hospital level has been posited as forming the backbone to assuring the delivery of efficient health care services. This brings to the fore the skills and expertise of hospital management to implement the executive duties set by the HSE regarding the delivery of frontline services. In turn, this highlights the distinguished roles of the HSE and the management at local hospital level. With regards to the HSE, its primary function is to provide an overarching framework in the achievement of efficiency. While at local hospital level, it is here where performance related efficiencies comes to fruition. Therefore, this highlights that the causes of inefficiency in recent times cannot be solely ascribed to the HSE organisation but rather to the performance of local hospitals in executing the delivery of services in a proficient manner (see chapter 5, section 5.10).

6.4.8 Conceptualising the principle of Accountability since the establishment of the HSE.

The managerial functionality bestowed on the HSE organisation discussed above signalled a disconcertion in the interview findings regarding the power of both policy actors and the Minister responsible at Departmental level to influence decisions in the realm of policy execution. This realisation was exasperated further by a perceived undefined relationship between the Department of Health and the HSE agency. Thus, a central issue to emerge has been the contentious disempowerment experienced at Departmental level in response to the devolving of full-operational responsibilities to the HSE agency in 2005. In this context, the principle inefficiency has been sourced in the lack of clarity and increasingly precarious relationship which has arisen between the Department of Health and the HSE in respect to responsibilities for health care provision. This is particularly reflected in instances of determining ‘eligibility’ of entitlement which is no longer the prerogative of the Department of Health. Therefore, from this interpretation it is viewed that the Department has effectively ceased responsibility due to the ‘policy’ and ‘operations’ divide that emerged following the creation of an autonomous HSE agency (see chapter 5, section 5.10). This separation in the policy remit formed a core tenet in the NPM ideals of ensuring more lean
efficiencies in the public service (Hood, 1991; Pollitt, 2001; Rhodes, 1996; see chapter 2, section 2.6).

As such, the lack of clarity surrounding the relationship between the Department of Health and the HSE has created political unease in respect to upholding the principles of accountability and democratic oversight in the health policy arena. This represents yet another contradiction to the established theoretical framework of NPM and SMI which advocates for a clear assignment of responsibility for action in the public sector with no diffusion of power. Essentially, this forms part of endorsing the doctrine of ‘hands-on-professional management’ in conducting public sector activities (Hood, 1991; PA Consulting 2002; see chapter 2, section 2.6). This is particularly pertinent in the context of the HSE whereby due to the sheer scope of the organisation, accountability becomes lost in the bureaucratic maze of the administrative layers and sub-layers. Furthermore, with the division of responsibility into policy and operational remits, this has raised considerable concern for parliamentarians during the post-HSE era regarding the maintenance of democratic oversight. As the interview findings depict, the HSE marked a new departure in respect to acquiring questions on the delivery of health care services in Ireland in an efficient manner. Hence, there is a perception that for ‘equality’ and ‘efficiency’ to be sustained, accountability is a necessary precondition that must be placed at the core of a health care organisation (see chapter 5, section 5.10).

The principle of accountability and democratic oversight also comes to fruition when contextualising the practice of ‘transparency’ regarding the fiscal aspect of health care provision. Under the administrative orthodoxy of the SMI, transparency was presented as a cornerstone guiding the actions of the public service (PA Consultants, 2002; see chapter 2, section 2.6). However, from the interview findings it was depicted that the practice of transparency within the HSE organisation was lacking in respect to strategic planning and accounting for where finance is procured in the process of health care spending. Therefore, efficiency is circumvented due to it being problematic to allocate ‘resources in areas of need’ when there is an apparent breakdown between linking strategically what is spent and the outcomes achieved from that source of spending (see chapter 5, section 5.10).
The issue of transparency and effective utilisation of fiscal funding has also been attributed to the presence in modern times of what was described in the interview findings as ‘historical sources’ of funding. As such, performance in service delivery in this instance was constrained due to the variation in longstanding historical sources of funding from one geographical area to the next. In turn, this had the effect of exasperating inequity and inefficiency in health care provision. Furthermore, it also made it increasingly difficult to quantify what is being spent strategically and the outcomes achieved due to the disparity in fiscal spending (see chapter 5, section 5.10).

6.4.9 Public perceptions on the impact of the HSE on service delivery: the ideal of efficiency in quality customer service.

Central to the modern conception of public administration through the SMI was the ideal of providing an excellent quality service to both the government and the public. This formed part of providing top-quality public services in a timely and efficient manner (PA Consultants, 2002; MacCartaigh, 2008; see chapter 2, section 2.6). In application to the Irish health care services, the interview findings highlight that the public perception in this regard was influenced by the predominance of the media in reporting on the inefficiencies of the organisation above that of the efficiencies achieved. Essentially, it was portrayed that the media engaged in negative reporting with regards to the HSE’s activities and in the process depicted the organisation as being an ‘abstract entity’ in which the administrators and the frontline staff on the ground such as; doctors and nurses were against each other (see chapter 5, section 5.10).

The portrayal of the HSE in an ineffectual prism has also been linked in the findings to its depiction as a ‘corporate entity’. In this regard, the word ‘executive’ in the HSE acronym and all which that concept encompasses has given rise to a public perception that those in the management tier of the HSE are ignorant to the happenings of health service delivery on the front line. Furthermore, it has been highlighted that the upper tier of executive management are publicly perceived to be responsible for not only national planning and management and delivery of health service, but also the delivery of health care services at local hospital level. Therefore, the existence of this public perception of the HSE’s operational structure enables the lower layers of the
organisation to evade in its responsibilities for its own actions (see chapter 5, section 5.10).

As a consequence, the branding of the HSE in this context has been perceived by policy actors internal to the organisation as becoming increasingly damaged in the years following the HSE’s establishment. The central reasoning for this is perceived to be due to the HSE being associated with every ‘mishap’ that occurs in the Irish health services. As such, with the corporate branding of the HSE (which is consistent with NPM framework of administrative governance see chapter 2, section 2.6) being under increasing public scrutiny, this has the effect of making the organisation a vulnerable target in placing blame for inefficiencies in service provision. In this context, it has been noted by one former policy actor that the political sphere in particular has been facetious targeting the HSE as source of all ills produced by the state’s health care system (see chapter 5, section 5.10).

6.4.10 Objective Two: Summary of the main findings.
In analysing recent reforms in the Irish health care arena, Health Acts, 1970 and 2004, it is evident that the instilment of ‘efficiency’ in the governance structure has far outweighed the desire to achieve ‘equality’ in the Irish health services. As such, there has been a clear reform agenda in modern times reflective of the principles enshrined in the New Public Management (NPM) Initiative; of which came to be applied in Ireland through the Strategic Management Initiative (SMI). This represented a reorienting of the public sector ethos from a focus on ‘inputs’ to ‘outputs’ in respect to policy outcomes and also the instilment of administrative practices such as: strategizing; performance measurement; and standards.

In the Irish health care arena, the emergent modern administrative practices were largely epitomised through the establishment of the Health Service Executive agency in 2005. The establishment of this executive agency was very much consistent with the drive of NPM in disaggregating the size of public bureaucracy. Within this framework, there was also a clear intent by policy actors to instil principles of: accountability; efficiency; standardisation; consistency; and coherence in the delivery of health care services. In
this regard, there have been notable efficiencies borne out of establishing the HSE as a centralised entity by comparison to what had previously existed. However, when observing the application of NPM ideals to the HSE in practice, this study has found that inefficiency has become a dominant feature. Issues such as the HSE’s absorptive role in respect to its remit of responsibility for a wide array of social services, rather than focusing exclusively on matters pertaining to primary and acute hospital care, has been cited as a central cause of inefficiency. Furthermore, inefficiencies were also borne in the failure to engage in a process of rationalisation, of which is a central premise of the NPM approach, following the establishment of the HSE agency. In this context, the study has found that through the involvement of the Trade Unions and the political haste at which the HSE was established this led to the growth of a bureaucratic intensive organisation with an excessive managerial outlook. A process of which has been described as leading to the disempowerment of those in the frontline of service delivery and at local hospital level. Furthermore, this study has also found that the ‘policy-operations’ divide regarding the roles of the Department and HSE has also served to infringe on democratic accountability and parliamentary oversight regarding the delivery of health care services. In addition, it has also acted to diminish the role of the Department in matters of policy implementation. Notwithstanding the evident inefficiencies to emerge, the study findings also reveal that the ‘corporate branding’ of the HSE has led to a negative public perception through the media on its effectiveness in health care delivery.

6.5 Conclusion.
This chapter examined how contemporary principles surrounding ‘equality’ and ‘efficiency’ in the Irish health care system evolved overtime. In egalitarian terms, this study has found that the modern ethos of equality governing health care provision is a Rawlsian conception of Social Justice and fair equality of opportunity in conjunction with a Libertarian ethos which arises in the utilisation of private sector techniques in health care provision. From this conceptualisation, it is evident that the primary focus, in egalitarian terms, is not with the achievement of an ‘outright’ vision of equality through for instance the provision of universal entitlement or the achievement of equality of
outcome in *health status* across the Irish population. On the contrary, the primary emphasis in the policymaking sphere has been on instilling a principle of ‘equity’ and a *spirit* of fairness in health service provision. In this sense, equality has been depicted as being ‘purposeful’ or ‘targeted’ in which the primary goal is to ensure that the poorest in society and those in most need receive public health care provision while the ‘able-bodied’ or those who can fend for themselves continue to do so. However, this ‘mixed-motives’ approach to service delivery has served to embed *inequality* in the Irish health care system due to it providing a fertile ground for discriminatory practices such as the public-private mix and two-tier access to evolve. Furthermore, the continued persistence of the policy construct, *eligibility of entitlement*, in consecutive health care reforms has served to effectively inhibit an ‘outright’ vision of equality emerging through a universal system of entitlement and access to health care services.

From the perspective of governance and the administrative process, this study has found that embedding a principle of *efficiency* in health service delivery has far outweighed a desire to achieve ‘equality’ in health service provision. Through an examination of the Health Acts, 1970 and 2004 in modern times, there has been a clear reform agenda towards the development of a ‘population health approach’ and ‘optimal patient outcomes’ in health service delivery. As such, the application of New Public Management principles through the administrative practices of: standardisation; consistency; and coherence in health service delivery were perceived in the policy sphere to be a necessitated precondition to the achievement of equality in health service provision. Despite this policy intent however, (in)efficiency in service delivery has been a predominant theme in contemporary times under the auspices of the Health Service Executive agency. In this context, elements such as the: failure to rationalise Human Resources; disempowerment of frontline personnel due to the excessive managerial ethos of the organisation; and loss of democratic oversight and accountability; have been cited as some examples impeding the achievement of efficient governance in contemporary times. In part, these inefficiencies have been attributed to the corporate ethos of the HSE organisation and its centralised function in the delivery of health care services.
In the following chapter, the themes of ‘equality’ and ‘efficiency’ examined in this chapter will be explored further through the research objectives surrounding the precepts of ‘continuity’, ‘institutional stability’ and ‘change’ in the policy trajectory of Irish health care reform.
Chapter Seven

Discussion:

Interpreting the process of ‘continuity’, ‘stability’ and ‘change’ in Irish health policy through an institutionalist theoretical framework.

7.1 Introduction

In comprehending the complexities and dynamisms associated with the internal policymaking environment, it is evident that the theoretical application of institutionalism, as a framework of analysis, has been largely uncharted in the literature examining the practice of Irish public policy. More specifically, there is a notable absence in the literature which critically explores how elements adhered to within a policymaking environment (i.e. path-dependent processes; cultural norms and institutional rules that are legitimated externally in society) can structurally constrain the behaviour of policy actors and in the process determine the policy outcomes produced. Therefore, I believe that through investigating the evolution of Irish health care reforms within the theoretical frameworks of historical institutionalism, sociological institutionalism and discursive institutionalism, this study has effectively filled a gap in the literature which examines the sphere of Irish social policy in this context.

This was accentuated through examining the precepts of: ‘continuity’; ‘institutional stability’; and ‘change’ in the trajectory of Irish health care reform within the frameworks of institutionalism theory. As such, the analysis focused on the structural constraints and limitations prevalent in the institutional environment of Irish health policy. This in turn facilitated an understanding of how policy actors overtime addressed intricate concepts such as equality of access and entitlement to health care provision. Thus, this thesis comprehends how policy visions of equality and entitlement came to be embedded and sustained over the Irish health care system’s course of evolution. Interpreting the process of ‘change’ also features as a central cornerstone in this study. In this context, emphasis is placed on analysing how the policymaking arena addressed
the concept of change in terms of reviewing/renewing conceptions of equality of access and entitlement and also in altering the governance structure that oversees the administration of the Irish health service.

In this chapter, the following core objectives of this study are discussed in respect to the institutionalism theoretical frameworks:

3. In historical institutionalism terms, how do the precepts of ‘continuity’ and ‘institutional legacies’ structurally shape policy outcomes in Irish health service provision?

4. From the theory of sociological institutionalism, how do cognitive, normative and regulative structures provide institutional stability and in that process shape the scope of welfare provision?

5. In terms of discursive institutionalism and the conceptual role of ideas and discourse in the trajectory of policymaking, how can the process of change be interpreted in Irish health care reform?

7.2 General discussion of Findings.

In chronicling how this mixed-motives framework came to be embedded and continued in the structuration of the Irish health care system, this study argues that the social policy course was one which maintained affinity to the principled ideals established during the Poor Laws era. As such, it is posited that the institutional legacies inherited from this period have been reinforced and at times rejuvenated during successive health care reforms. This is particularly relevant when observing how the concepts of deserving and undeserving poor evolved to become the policy instrument determining eligibility of entitlement to publicly funded health care services. Similarly, it is interesting to observe how other significant principles from this period such as: individualism; self-help and laissez-faire market idealisms evolved to form the impetus for establishing private health insurance and neo-liberal policy conceptions of the public-private mix and incentivising of the private sector. Therefore, both the
institutional legacies from the past and the continuity of the policy course in health care reform provides an understanding as to how the ‘mixed-motives’ framework came to be sustained overtime.

Furthermore, the continuity of the mixed motives system is also reflective of a desire to maintain public support and stability in the policymaking field. As such, this study argues that the policy outcomes (e.g. eligibility of entitlement and private health care) produced is consistent with the prevailing cultural sentiments or norms legitimated externally in society.

While ‘continuity’ and ‘institutional’ stability’ are dominant themes which characterise the evolution of health care reform, the study findings reveal that ‘incremental change’ also features within the institutional dynamics governing health care provision. Through achieving ‘consensus’ on the discursive paradigms governing health care provision amongst stakeholders (e.g. the public, government, opposition parties, vested interests) change becomes possible. However, in the Irish case, the primary change to occur relate to the instruments overseeing the implementation of public policy (i.e. health boards, HSE administrative structures) rather than the overarching goals in service provision (i.e. eligibility of entitlement/means-testing).

7.3 In historical institutionalism terms, how do the precepts of ‘continuity’ and ‘institutional legacies’ structurally shape policy outcomes in Irish health service provision?

As established previously in research question one (see chapter 6, section 6.3), the prevailing egalitarian idealisms dictating the policy paradigm of health service delivery is a combination of: a Rawlsian interpretation of social justice and fair equality of opportunity; equity; and a libertarian stance of individual responsibility/self-help. From this conceptual derivation, the object of this section is to explore through the findings how this theoretical paradigm came to be initiated and subsequently sustained in the policy evolution of health care reform. As such, this section is going to examine how the policy practices of: ‘eligibility’ of entitlement to public health care services; and the two-tiered system of public-private access to acute hospital services came to be enshrined and sustained on a ‘continuous’ policy trajectory.
Through the theoretical underpinnings of historical institutionalism – path-dependent analysis and the critical juncture – it can be ascertained how ‘continuity’ and ‘institutional legacies’ formed a crucial role in sustaining the libertarian and egalitarian principles which characterises Irish health care provision in the modern context.

7.3.1 Historical Institutionalism: The theorisation of Critical Junctures and Path-Dependent analysis.

In a generic sense, the historical institutionalist literature affirms that political institutions and public policies established previously influence the behaviour of policy actors, elected officials and vested interests during the course of policymaking. Hence, the historical institutionalist perspective places significant emphasis on the structures of the ‘institutional environments’ of policymaking which shape and constrain goals, opportunities and actions of policy actors and vested interests operating within the institutional environment. Furthermore, this theoretical model examines the ‘constraints’ and ‘opportunities’ which present themselves in the policymaking process and are determined within an historical context. As such, when analysing the evolution of public policy, the historical institutionalist approach emphasises on the process of: timing; sequencing; unintended consequences; and policy feedback (Beland, 2005; Ikenberry, 1994; see chapter 3, section 3.3). This focus on the historical process is codified within the theoretical framework of path-dependent analysis and the critical juncture. Therefore, from this summation of the historical institutionalism literature findings and its application to the policymaking process, it can be derived that ‘continuity’ and the existence of ‘institutional legacies’ can directly impact on attempts to induce health care reform moving forward.

When evaluating the evolution of the Irish health care system within the theoretical framework of path-dependent analysis and the analogy of the critical juncture, it is attributable that the practice of ‘eligibility of entitlement’/‘means-testing’ and the ‘two-tier system of the public-private mix’ in health care provision are products of ‘institutional legacies’ inherited from earlier legislative enactments. This theoretical process was succinctly described by Max Weber (1946) who stated that politics and society runs on tracks which are laid down at crucial moments during a country’s
history. According to this principle, the element of continuity occurs when in the event of new ‘idealisms’ coming to the fore that potentially threaten to override a policy trajectory, policy actors and stakeholder groups nonetheless pursue their interests along the *established* paths laid down by existing political institutions. Therefore, path-dependent theorists operate under the assumption that events at an earlier point in time will affect the sequence of potential policy outcomes at a later point in time (Scharfp, 1997; Mahoney, 2000; Sewell, 1996; Pierson, 2004; see chapter 3, section 3.3).

The process of path-dependency in this study is integrated further through the theoretical construct of the critical juncture. In the literature findings, the critical juncture was projected as an occasional moment in history where after a relatively long period of path-dependent stability there are brief periods of institutional flux whereby dramatic change is possible. Additionally, the policy outcomes undertaken during a critical juncture are understood to have a lasting effect on the policy course as these choices close off alternative options. This in turn leads to institutions generating a self-reinforcing and path-dependent process (Cappoccia and Kelemen, 2007; Mahoney, 2000; see chapter 3, section 3.3).

7.3.2 Path-Dependency and Critical Junctures in practice: *evolution of the Irish health care system in the context of equality and efficiency principles.*

In the context of the evolution of the Irish health care system, this study identified seven critical junctures which demonstrate, through the process of ‘continuity’ and existence of ‘institutional legacies’, how the policy precepts of eligibility of entitlement/means-testing and the two-tier system of the public-private mix became embedded. The core critical junctures established in this instance are re-surmised in Table 7.1 below;
7.3.3 Foundations of the Irish health Care System: instilling the principles of ‘eligibility of entitlement’ and the ‘two-tier public-private mix’ in the Irish health service.

At a foundational level, the Irish Poor Laws era represents a fundamental juncture in the development of the health care system in Ireland. This is based on two factors. Firstly, the institutional infrastructure of the workhouse, which was initially designed to act as a deterrent in dissuading citizens to seek public welfare provision, later transformed to an entity closely resembling the modern hospital system (Kidd, 1999; Burke, 1987; Brundage, 2002; see chapter four, section 4.2). In the second instance, the Irish Poor Laws era embedded a lasting institutional legacy on the policy landscape of social provision. Through establishing the policy precepts of: deserving and undeserving poor; less-eligibility; and the workhouse test; this enshrined in the course of social provision an early ‘eligibility of entitlement’ measure to state funded welfare services. Furthermore, it also identified and categorised the lower-socio economic classes in society as those who could not afford to pay for welfare services and were ‘in most need’ of state assistance. Hence, the institutional legacy that originated during this period later transformed to become, in the modern context, the eligibility of

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Table 7.1 Critical Junctures which have shaped the evolution of health care provision in Ireland.

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<tr>
<th>1. The Irish Poor Laws</th>
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<tr>
<td>2. The establishment of the Dispensary System, 1851</td>
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<td>3. Health Insurance Act, 1911</td>
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<td>4. Mother and Child Scheme, 1947</td>
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<td>5. The establishment of Voluntary Health Insurance (VHI), 1957</td>
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<td>6. Health Act, 1970</td>
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entitlement/means-testing criterion for receiving the GMS medical card and the classification of the ‘public patient’.

In terms of contextualising this embryonic era of social provision within the theory of historical institutionalism, it is evident when applying Weber’s (1946) analogy that the political institution during this period established a ‘track’ in which social policy outcomes moving forward were to reinforce and regenerate the idealisms of individual responsibility and self-reliance68 in respect to those who could afford to pay and a policy construct of eligibility of entitlement to ensure that the lower socio-economic classes/poor in society received welfare support from the state. In turn, this signalled the origins of the modern classification of the ‘private’ and ‘public’ patient status in the Irish health care system.

The establishment of the *Dispensary System, 1851* was also interpreted in the findings as representing a significant critical juncture in the foundation of the Irish health services. As such, the infrastructure of the dispensary system symbolised a cornerstone to the further modernisation and development of the Irish health care system. From this standpoint, it is evident that the characteristics which we associate with the modern health care system can be traced back to this developmental milestone in the evolution of medical services. This sentiment was also reflected in the interview findings where it was observed how the dispensary system laid the foundations of what was to become the ‘public’ health care system (see chapter 5, section 5.8).

In retrospect, this study has found that the development of the dispensary system formed as part of a series of significant infrastructural transformations occurring in the delivery of health care services. The marked increase of state-involvement in the administration of health care services during this period was principally due to the mass levels of impoverishment. As the findings reveal, the offset of the Great Famine led to the further development of the dispensary system as an early form of primary care services (Cassell, 1997; Geary, 2004; see chapter 4, section 4.3). Therefore, from this historical derivation the features that characterise the dispensary system’s establishment

68 The idealisms and cultural norms which informed the conceptions of ‘individualism/self-help’ and the classification of the ‘private’ and ‘public’ patient shall be discussed in more detail in the discussion on subsequent section on sociological institutionalism.
as a critical juncture was the shift in ideological thinking regarding the role of the state in welfare provision. As the findings reveal, this was demonstrable in the increased activities of the state in a social sphere which was previously dominated by the voluntary/philanthropy sectors (Cassell, 1997; see chapter 4, section 4.3). However, despite this shift in state policy in respect social provision, continuity and the existence of institutional legacies were also present factors determining public policy at this juncture.

In particular, it is evident that the policy precepts of eligibility established during the Poor Laws era was continuing to influence policy outcomes. As such, this early policy measure of ‘eligibility of entitlement’ to public provision was continued and developed further under the dispensary system – through the operation of the E1-black and E2-red cards. In the context of the former, this entitled patients to free public access to dispensary services while the latter facilitated a ‘medical practitioner visit’ to the sick poor in their homes (Cox, 2010; Barrington, 1987; Cassell, 1997; see chapter 4, section 4.3).

Through enshrining this public entitlement criterion, this further reinforced the principle of ‘individualism and self-help’ for those who could afford to pay for their welfare services while the state in a ‘paternalistic fashion’ provided for the poorest in society. Therefore, from this embryonic stage in the development of the Irish health services, it is evident that ‘universal access’ to health care provision was not to form a defining characteristic in the institutional framework. On the contrary, this juncture, through encapsulating the principle of ‘eligibility of entitlement’ as a determinant of access to dispensary services, effectively demarcated between private (fee-paying) and public (non-fee paying) patients. In the subsequent section, it will be explored through the theory of path-dependent analysis how the policy course established during the Poor Laws era and the dispensary system generated a powerful cycle of self-reinforcing activity (Pierson, 2004; Immergut and Anderson, 2008; chapter 3, section 3.3). This is primarily based on the findings which demonstrate that with each step down the established ‘track’ this increased the attractiveness of social service provision based on

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69 The social ideals and cultural values which were significant in the instilment of ‘private’ and ‘public practice’ in this context shall be explored in more detail in the subsequent research question.
the precepts individualism/self-help through a flourishing private health care sector and for the lower income groups, eligibility of entitlement to access publicly funded health services.

7.3.4 Self-reinforcing sequences and the process of increasing returns: Assessing the process of continuity in the reforms which shaped the modern health care system.

The self-reinforcing generative capacity of the policy trajectory established during the Poor Laws era becomes self-evident when evaluating the political institution’s response to the idealism of universal access which was enshrined in the National Health Insurance, 1911 and the Mother and Child Scheme, 1947 critical junctures. These two historic moments in the evolution of the Irish health care depict concisely Mahoney’s theoretical interpretation of the critical juncture (2000; see chapter 3, section 3.3).

This is based on the premise that both historical moments were ‘counterfactual’ and ‘contingent’. In terms of the counterfactual element, due to both reform agendas being primarily motivated towards extending health service provision through universal access, this represented an attempt by reformers to consider an alternative policy option to the existing individualist/self-help and eligibility of entitlement principles that dominated the policy discourse (Briggs, 2006; Powell, 1992; Barrington, 1987; Adshead and Millar, 2003, Wren, 2003; Cooney, 1999; Browne, 1986; see chapter 4, sections 4.4 and 4.5). The ‘contingency’ element lies in the premise that the policy option selected was unforeseen by the policy actors. In the context of National Health Insurance Act, 1911 and Mother and Child Scheme, 1947, both reformers, Lloyd George and Noel Browne, did not foresee the outright rejection of their reform agendas and the reinforcement of the original status quo in health care provision. As the sociological institutionalist interpretation of these two critical junctures shall depict in more concise detail below, the self-reinforcing sequence which emerged was due to the opponents of reform in both instances – the Catholic Hierarchy and Medical Profession – adherence to the idealisms of individualism/self-help in tandem with their deep contestation towards state medicine (which universal access was perceived to imply).
As such, the rejection of the *universal access* to health care services in favour of the status quo depicts a ‘functionalist’ interpretation of institutional reproduction. In applying Mahoney’s derivation, the reason for maintaining the policy ‘track’ established during the Poor Laws era is due to it serving a ‘function’ within the overall system (Mahoney, 2000; chapter 3, section 3.3). This is particularly apparent when contextualising the opposition of vested interests to Browne’s Mother and Child Scheme, 1947. On the part of the Catholic Hierarchy, upholding the *laissez-faire* principles of individualism/self-help in health care provision proved to be consistent with Catholic Social teaching on; non-state intervention and protecting the private sphere of the family through welfare provision. Furthermore, the Church’s conquest against ‘socialised medicine’ and maintenance of the status quo was also depicted as an attempt to offset the perceived threat of ‘communism’ stemming from the Eastern Europe. For the Irish Medical Profession, the ‘institutional legacy’ of individual responsibility and self-reliance was consistent with the idealism of preserving their right to engage in ‘private practice’ (see chapter 4, section 4.5).

Preserving the policy construct of ‘eligibility of entitlement’ to public health care provision also served as a function within the wider system in which the institution was embedded. As the policy construct served to ensure that the poorest sections in society received basic health care services. Hence, the ‘function’ of the Irish health care institution was never to provide outright equality, through ‘universal access’ for all, but rather to ensure that the poorest sections of our society were provided for.

In addition to the functionalist interpretation of institutional reproduction, Mahoney (2000) and Hall and Taylor (1996) describe how self-reinforcing path-dependent processes can also be depicted within a ‘asymmetrical power centred’ approach (see chapter 3, section, 3.3). Within this context, institutions can persist irrespective of most individuals or groups who prefer to change it. This in turn projects that if an ‘elite’ group benefit from existing institutional arrangements, it has sufficient power to regenerate its reproduction. In the context of the Irish health care system, the findings reveal that the dominant elite (the Catholic Hierarchy and the Irish Medical Profession) during the Mother and Child Scheme period, held sufficient power to promote its reproduction. The source of this power resonated in its undue influence and
the representation of vested interests at the cabinet table of the Irish state’s first coalition government.70

Thus, when contextualising the Mother and Child Scheme in terms of path-dependent analysis, the status quo came to be sustained further through the Health Act, 1953 (see chapter 4, section 4.5). This enactment embedded an eligibility of entitlement criterion in which access to public health care services was to become based on an income threshold. While this enactment was presented in the findings as representing a substantial development in extending hospital care to the population, it nonetheless reflects a restrictive vision in respect to the enhancement of equality. At this point, it was evident that the Irish health care institution was traversing down a path which was not susceptible to the development of a state medical service. Through preserving the medical professions right to private practice, this marked the development of a unique relationship between the state and the private sector in health care provision.

This relationship came to be copper fastened under the Voluntary Health Insurance, 1957 critical juncture (Curry, 2006; O’Morain, 2007; Wren, 2003; see chapter, 4, section 4.6). Through offsetting the development of a ‘state medical service’ and in preserving the medical professions perceived right to practice private medicine, the VHI formally codified the establishment of two distinct classes of patients in Irish health care provision. Therefore, in the Irish health care landscape this led to the formal status recognition of a ‘public patient’ (those patients who are eligible for free-health care services) and a ‘private patient’ (patients who are ineligible for free health care services and who must purchase health care through the insurance market). As such, this critical juncture stipulated that policy alternatives such as ‘state medical service’ and ‘universal access’ were, in accordance with Cappoccia and Kelemen’s (2007; see chapter 3, section 3.3) definition, closed off. From this standpoint, the establishment of the health insurance market during this juncture symbolised a self-reinforcing path-dependent process whereby the principles of ‘individual responsibility’ and ‘self-reliance’ enshrined in the laissez-faire Poor Laws period came to be sustained further.

70 The significance of the influence of the vested interests in this context will be explored below within the theoretical framework of sociological institutionalism.
Despite the significant transformation of the Irish health care system to emerge within the *Health Act, 1970* critical juncture (Barrington, 1987; Wren, 2003; see chapter 4, section 4.7) this did not alter the path-dependent track established at previous junctures. Similar, to the *National Health Insurance, 1911* and *Mother and Child Scheme, 1947* critical junctures, policy options were also presented to alter the policy trajectory in which health care was provided in Ireland. For instance, the Labour Party in opposition proposed the introduction of a ‘health service for all’ funded through central taxation and insurance contributions. Whilst Fine Gael in opposition proposed the introduction of a comprehensive health care system for 85 per cent of the population to funded through insurance contributions.

However, the Fianna Fáil government during this period demonstrated little appetite for altering the policy trajectory established. As the findings reveal, ‘continuity’ proved to be a central facet at this juncture in that the philosophical ethos of health care provision remained unchanged. This was demonstrated through the formal codification and embedment of the policy constructs ‘eligibility of entitlement’/‘means-testing’ to free health care services. Therefore, the institutional path moving forward from this critical juncture was one that emphasised on providing free health care for the ‘poorest’ in society and sustaining the private health care market (through health insurance) for those who could afford to pay. This idealism came to be sustained further in the *Health Act, 2004* critical juncture, in that the establishment of the Health Service Executive agency did not alter the ethos surrounding access to health care provision.

From the above critical junctures reviewed in the findings, it has been articulated within historical institutionalism theory how the principles established in the Poor Laws era, namely: the idealisms of individual responsibility and self-reliance; and the policy construct of eligibility of entitlement criterion was sustained and regenerated in subsequent health care reforms.

In contextualising this self-reinforcing sequence within the framework of path-dependent analysis, Arthur (1994 cited in Pierson, 2004; see chapter 3, section 3.3)

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71 The Health Act, 2004 juncture and its implication on the Irish health care provision shall be discussed in more concise detail below.
argues that the reproduction of institutions or positive feedback has a number of distinct features which are:

- **Unpredictability** – throughout each critical juncture in the evolutionary process alternative policy outcomes to the status quo were offered – which were namely related to the introduction of a state medical service, social insurance and universal access. Despite this, it is not possible in theory to predict ahead of time which of these possible end-states will be reached.

- **Inflexibility** – implies that the farther into a process we are the harder it becomes to change from one path to another. The findings reveal that this proved to be the case in the Irish health care context. In particular, this was demonstrable in the *National Health Insurance, 1911* and *Mother and Child Scheme, 1947* critical junctures. Despite the theme of ‘universal access’ being contained in both reform initiatives, it was not possible to override the path-dependent track which was established in the *Poor Laws* and *Dispensary System, 1851* critical junctures. This demonstrates that as the Irish health care system evolved, the policy constructs of eligibility of entitlement and the use of the private sector (as a reflection of the idealisms of *individual responsibility* and *self-reliance.*) came to be ‘locked-in’ as one solution. It in turn came to be recognised as an increasingly attractive policy direction.

- **Nonergodicity** – implies that events early in a sequence do not cancel out. They cannot be ignored because they feed into future choices. In the context of the Irish health care system, the policy outcomes produced during the *Poor Laws* and the *Dispensary System, 1851* critical junctures had a lasting impact on future policy decisions. This study has found that these early policy outcomes contributed to shaping the contemporary policy constructs of eligibility of entitlement and the two-tier system in health service delivery.

- **Potential path inefficiency** – despite the inefficiencies which the policy trajectory may generate in the long-run, it is nonetheless sustained. As such, this provides an explanatory position as to how the inequalities present in the current policy path – e.g. two-tier system of access to acute hospital care – remains a dominant feature characterising the Irish health care system.
In application to the Irish health care system then, it is evident that the ‘self-reinforcing’ processes described make policy reversals increasingly unattractive over a period of time. This is primarily based on the premise that establishing new institutions or policies generate what Pierson (2004; see chapter 3, section 3.3) describes as high ‘fixed costs’, ‘learning effects’, and ‘adaptive expectations’. Hence, this has the effect of constraining a policy actor’s behaviour in the decision-making process onto paths which in the long-run are difficult to reverse.

7.3.5 Objective Three: Summary of main findings.

It is evident from the findings that the features which contribute to inequality in the Irish health care system in the contemporary context are part of a path-dependent process which have been self-reinforced and regenerated in subsequent social policy reforms following the Poor Laws era. The institutional reproduction of this path-dependent trajectory has served as a function; which is to preserve the idealisms that informed the policy process during the Poor Laws era. These principles are namely: the ideological predisposition of individual responsibility; self-reliance; and a policy construct of eligibility of entitlement. As such, this study has discovered that the object of public policy within this path-dependent trajectory was not to instil equality through universal health care but rather to protect the poorest in society through state intervention while the able-bodied fended for themselves. In turn, this sentiment, in which the Irish health care system is founded, provides an explanation as to how the private health care sector has flourished with the passing of each consecutive reform while policy initiatives surrounding universal health care coverage have been defeated.

7.4 From the theory of sociological institutionalism, how do cognitive, normative and regulative structures provide institutional stability and in that process shape the scope of welfare provision?

From the previous section, the primary objective was to demonstrate through the theory of historical institutionalism how the structural features which define modern health care provision came to be embedded and reproduced. In conjunction with the sociological institutionalist perspective, an understanding is facilitated on how the philosophical
ideals, cultural values and norms which are formed in society overtime come to influence the development of structural institutional elements. Hence, it provides further insight into the Irish state’s resistance towards social provision measures with an egalitarian ethos of universal access. As such, this study has found that during critical moments in the nation’s history, political ideals and the existence of prevailing cultural norms and values in society played a crucial role in shaping the relationship between the State and its citizenry regarding what can be expected by means of welfare provision.

In this section, the focus will be to analyse how social policy outcomes are guided by prevailing cultural norms, cognitive frames and meaning systems which in turn facilitate both institutional stability and determine the shape and scope of welfare provision.

7.4.1 The influence of cultural norms and cognitive framing in the creation of institutions.

The sociological literature defines an institution as being characteristic of a formal organisational structure which contains elements of patterned social behaviour through: the roles performed; rules adhered to; and in some instances engagement in scripted behaviour. From this definition of an institution, it is attributable that the primary function is to act as a ‘constraint’ mechanism that is designed to shape human action in the devising and implementation of public policy (Bell, 2002; North, 1990; Steinmo, 2008; Keoble, 1997; March and Olsen, 1997; see chapter 1, section, 1.3.2). In contextualising this further in terms of sociological institutionalism then, the primary object is to offer a unique approach to examining the practice of ‘creating’ institutions rather than the ‘structural’ features that result from that development. Hence, sociological institutionalism reflects on how socially constructed and routine based rule systems actively constrain the behaviour of actors within the ‘internal’ policymaking environment (Jepperson, 1991; Scott, 1995; Peters, 2012; see chapter 3, section 3.4).

Through analysing the evolution of Irish health care within this theoretical framework, it can be articulated how ‘cultural frames’ form a central tenet in shaping the scope and future direction of institutional organisations. Thus, the institutional legacies which come to be established overtime originate from the prevailing cultural
norms and value systems dominant in the ‘external’ environment. The cultural frameworks in turn are then assimilated into the ‘internal’ institutional environment. This theoretical derivation is reinforced further through the process of institutional isomorphism. Within this process, the cultural frameworks – containing the social, political and economic idealisms – legitimated externally act to enhance the commitment of both ‘internal’ participants and ‘external’ vested interests to the institutional organisation and in turn the public policies produced. Furthermore, institutional stability also occurs as the assimilation and harmonisation of cultural frameworks establishes consistency within the policymaking framework of the internal policymaking environment and thus reduces turbulence and sustains continuity (Meyer and Rowan, 1991; see chapter 3, section 3.4).

As such, the cultural frameworks prevalent in society possess the power to both shape and impact the decision making process. This is based on the premise that the cultural frameworks and norms legitimated externally in society form the institutional rules of the game which in turn dictate the behaviour of policy actors. Consequentially, the cultural frames assimilated effectively constrain the decision-making behaviour to reflect the norms and conventions embedded in the overarching institutional structure. This in turn contributes to ensuring stability in the policymaking process. By implication, the behavioural conduct of policy actors comes to be dictated through the existence of ‘informal’ rules. These rules develop from the incorporation of the prevailing cultural norms and value systems practiced in society. In applying this theoretical process to the Irish health care system’s evolution, it is evident that the operating cultural frameworks during the critical junctures acted as a crucial determinant of policy outcomes.

7.4.2 Sociological institutionalism: cultural frames, the institutional rules of the game and the foundations of the Irish health care system.

One of the central facets of sociological institutionalism in its definition of institutional organisations is to assuage how the ‘internal’ environment within which a policy actor functions comes to be shaped by prevailing cultural norms and value systems prevalent in society. In this regard, the theoretical construct of institutional isomorphism dictates
that policy actors cannot make decisions in a ‘rational’ or ‘individualised’ manner due to the constraints imposed by the existing cultural frameworks in society. In turn, these informal cultural norms and value systems come to be expressed in the shared meanings and taken-for-granted intersubjective world view of policy actors within the institutional environment of public policy (North, 1990; see chapter 1, section, 1.3.2; Meyer and Rowan, 1991; see chapter 3, section, 3.4).

This study has found that the evolution of health care provision has been subject to both the influence of cultural frames and the theoretical process of institutional isomorphism. At a foundational level, the *Irish Poor Laws* era represented a crucial period in that it led to the creation of an ‘institution’ which was to leave a lasting imprint on the terrain of Irish health care policy. In this regard, it can be articulated through the process of institutional isomorphism that the prevailing orthodoxy of classical liberalism and the economic doctrine of *laissez-faire* capitalism were predominant ideological forces to dominate the cultural framework legitimated in the ‘external’ environment.

One of the central features of classical liberalism was its upholding of the ‘night-watchman state’ and the conservative ideological position of the ‘free individual’. Through this ideological framework, it was reinforced in both the social and economic spheres that individuals should function as independent agents/entrepreneurs free from state intervention. This came to be particularly intertwined in the economist Adam Smith’s philosophical vision of a society in which an individual can fulfil their potential unrestricted by regulations that would serve to infringe liberty (Fraser, 1984; Taylor, 1972; Clarke *et al.*, 1987; see chapter 4, section 4.2). Therefore, the ideals of staunch individualism and the upholding of the free-market were interwoven in the cultural and value system framework adhered to in society during this period.

In terms of conceptualising the significance of the ‘external’ and ‘internal’ institutional environments in the development of public policy, it is evident that the origins of the precepts *deserving* and *undeserving poor* were reflective of this ‘individualist’ sentiment present in society. As such, those who were found to be ‘undeserving’ or ‘able-bodied’ poor in status were expected to fend for themselves and their families through active engagement with the employment market without undue
reliance on the state. Furthermore, the establishment of the ‘workhouse system’ was also a product of the individualist/self-reliance sentiment in that it was designed with the intent of making state relief an unattractive source of welfare in times of distress. Hence, its primary function was to act as a deterrent from seeking social provision from the state. The advancement of this philosophical vision of the ‘free individual’ was not only espoused in the ‘external’ environments of the political and economic spheres. It was also legitimated at a societal level generally; as the concepts of ‘self-help’, ‘charity’ and ‘survival’ were dominant cultural frameworks informing the practice of welfare provision during the Poor Laws era. In this regard, it was demonstrated that in avoiding state assistance through the workhouse system, individuals were encouraged to seek mutual assistance within the social networks of family and friends in times of distress (Clarke et al., 1987; Thane, 1996; see chapter 4, section 4.2).

When interpreting the influence of cultural frameworks and norms in the ‘external’ environment further, it is evident that the policy concepts of ‘deserving’ and ‘undeserving’ poor were idealisms not solely developed in the ‘internal’ environment of public policymaking. On the contrary, it is apparent when analysing the operating practice of charitable sources of assistance or so-called friendly societies that the sentiment of *laissez-faire* economics and *individualism* were predominant principles governing the ethos of philanthropic activities. As individuals deemed to lack in ‘thriftiness’ or regarded as ‘undeserving’, were forced to seek assistance of the state, through the workhouse, as a last resort possible in the event of destitution. From the perspective of sociological institutionalism then, this demonstrates the process of institutional isomorphism in the practice of public policymaking. As the ideological ethos of *classical liberalism* present ‘externally’ in society was effectively legitimated and came to be reflected in the minimalist form of welfare intervention during this period. In addition, due to Ireland being part of the British Empire during this period, the terrain of Irish social policy was also subject to this cultural and normative framework influencing the policy arena of welfare provision (see chapter 4, section 4.2).

The policy deliberations which led to the extension of the poor laws to Ireland also raised some noteworthy correlations with the theory of sociological institutionalism. As such, this is particularly pertinent when analysing how the
recommendations of the initial report chaired by Richard Whately came to be rejected due its generous stance on social provision. While the second report headed by a well-known *laissez-faire* ideologue, George Nicholls came to be implemented. The central reason for this was primarily due to the report recommendations of Whately conflicting with the cultural frameworks of individualism and minimalist welfare state intervention that were legitimated in society during this period. By contrast, due to the Nicholls report being largely reflective of the norms and value system espoused in the ‘external’ institutional environment, its recommendation for the extension of the English Poor Laws (the workhouse system) to Ireland through the Poor Relief (Ireland) Act, 1838 came to be implemented (Burke, 1987; see chapter 4, section 4.2). Hence, the recommendations of Nicholls essentially went ‘with the grain’ regarding both the prevailing cultural framework in the ‘external’ environment and government policy at this juncture. As such, this assured institutional stability and reduced the possibility of turbulence in the institutional environment of public policymaking.

Within a sociological institutionalist interpretation then, this demonstrates concisely the operative practice of the *institutional rules of the game* in the policymaking environment in which policy actors function (Steinmo, 2008; see chapter 1, section 1.3.2). In this sense, it is apparent that ‘adherence’ rather than ‘defection’ from the prevailing cultural frameworks legitimated externally in society proves to be a powerful force in dictating the scope and direction of social policy.

When contemplating this process in terms of the evolution of the Irish health care system, it can be articulated that the Poor Laws juncture established the initial demarcation lines to what would evolve to become ‘private’ and ‘public’ forms of welfare provision. As such, the frameworks of ‘individualism’ and ‘self-reliance’ proved to be a significant precursor in facilitating the growth of private medical practice in Ireland. Furthermore, prevailing attitudes towards ‘public’ provision, through the workhouse system, highlighted that the direction of public policy was not going to be ‘universal’ in respect to entitlement. Rather, at this foundational stage in the development of social services, the idealisms surrounding the workhouse system signalled that the role of the state moving forward was to provide relief for those in most ‘need’ in society. Hence, the concept of entitlement reflected through the principles of
The establishment of the dispensary system proved to be significant in extending this foundational demarcation between ‘public’ and ‘private’ forms of social provision. From the outset, the dispensary system was designed to provide health care to the most destitute in society following the destruction caused by the Irish Famine. While this may have been the primary catalyst to government intervention, there were other factors also prevalent such as the lack of financial resources to support health care provision in the Irish countryside during this period. Furthermore, despite the dispensary system displaying a symbolic move towards the introduction of an eventual state medical service, the desire to uphold the possibility of private practice evolving upon economic betterment far superseded an intention to develop universal health care (Geary, 1994; Barrington, 1987, chapter 4, section 4.3). From this critical juncture then, it is evident that there was a cultural sentiment prevalent in Irish society which was susceptible the evolution of private medical practice. Therefore, in the context of sociological institutionalism, it is evident that the external environment at this embryonic stage legitimated the provision of health care in both the public and private sector realms.

As such, this derivation of ‘public’ and ‘private’ sources of social provision is reinforced further through the establishment of the E1-black and E2-red ticket system, as a determinant of entitlement to dispensary services (Cox, 2010; see chapter 4, section 4.3). This firmly redefined the ‘deserving’ and ‘undeserving’ poor criterions utilised under the workhouse system. Hence, in preserving the ideals of ‘individualism’/‘self-reliance’ regarding private welfare provision and ‘eligibility of entitlement’ to public service provision, this highlighted that the cultural frameworks influencing the initiation of public policy in the ‘internal’ environment had not changed drastically from what had previously existed. Rather, the transition from the Poor Laws era to the Dispensary system critical juncture represented a process of refining the cultural norms and value system framework embedded earlier. This is particularly prevalent when analysing the early formation of the ‘public’ and ‘private’ patient status differentials.

From a sociological institutionalist interpretation, this proved to be significant in that it represented the emergence of a cultural framework that sustained a form of
‘apartheid’ in demarcating between ‘public’ and ‘private’ patient treatment. During the dispensary system period, this came to be reflected in the cultural perceptions of public patients as being ‘infectious’ and treated separately from private ‘fee-paying’ patients. As such, private patients were culturally perceived to be respectable and, by contrast to public dispensary patients, warranted treatment in the home or surgery of the medical practitioner (Barrington, 1987; chapter 4, section 4.3). Therefore, the ‘external’ environment in this sense was displaying a background cultural sentiment which endorsed the emergence of an ideology of private medical practice in a discriminatory manner.

The effects of the prevailing cultural perceptions and frames derived in this context has been succinctly addressed by sociological institutionalist theorists such as Hall and Taylor (1996) and Di Maggio and Powell (1991) who posit that within a cognitive dimension, institutions can influence the norms of behaviour through the ‘scripts’ that governs the interaction of policy actors (see chapter 3, section 3.4). This contends that an institution acts as a product of the cultural framework legitimated in the external environment which impacts not only the strategic calculations derived but also the basic preferences and very identity of policy actors. Hence, the actions of policy actors in the internal institutional environment incorporates ‘images’ and ‘signs’ provided by social life in the implementation of public policy.

7.4.3 National Health Insurance and Mother and Child Scheme: Cultural frames and norms which offset policy initiatives of Universal health care entitlement.

In evaluating the foundations of Irish health care provision, it is evident that the core concepts of: individualism/self-reliance; eligibility of entitlement; and public-private forms of welfare provision were reflective of the background cultural sentiment in society during this period. Once established, the cultural frameworks legitimated acted as a stability mechanism within the internal structure of the institutional environment. As stated previously, these institutional norms and scripts act to constrain and shape the preferences of policy actors whilst simultaneously determining the scope of policy outcomes (Hall and Taylor, 1996; Di Maggio and Powell, 1991; see chapter 3, section 3.4). As such, the element of institutional stability that surmounts from this
harmonisation of the behavioural norms between policy actors and the prevailing cultural norms and frameworks in the ‘external’ environment has the effect of reducing ‘turbulence’ in respect to the policy outcomes produced.

Hence, the theoretical process of institutional isomorphism dictates that with incorporating externally legitimated formal structures and cultural perceptions on what constitutes social provision this in turn enables the institutional organisation to survive and succeed in the field of public policy implementation. With the harmonisation and sense of commitment that emerges between the ‘internal’ participants and ‘external’ constituents to an institutional organisation, this creates a stable trajectory in the policymaking process and by social definition makes it difficult to fail (Meyer and Rowan, 1991; Hall and Taylor, 1996; Di Maggio and Powell, 1991; see chapter 3, section 3.4).

From this theoretical framework, the interwoven relationship between cultural norms and social constructions with that of the policymaking environment provide an understanding as to why ‘universal’ principles of access to health care were consistently refuted. As such, the failure to introduce universal entitlement in the National Health Insurance Act, 1911 and the Mother and Child Scheme, 1947 critical junctures was due to the principle ideals attached to the reform proposals being incompatible with the background cultural sentiment present in Irish society. For instance, with the National Health Insurance Act, 1911, the universal principles espoused were not legitimated ‘externally’ in society due to the cultural environment in the Irish context displaying conflicting frameworks for social action, such as the: nationalism espoused through the political elite of the Irish Party; conservatism in the social teachings of the Catholic Church and the agrarian nature of the economy/society generally; ideals of individualism/self-reliance; and the principle of public-private forms of social provision (see chapter 4, section 4.4). Consequentially, the conflicting frameworks resulted in the creation of turbulence in the institutional environment.

By contrast to the previous critical juncture surrounding the foundations of the Irish health care system through the establishment of dispensary system, the National Health Insurance Act, 1911 depicts how when faced with an alternate set of policy ideals – in this instance a model of social insurance – the path-dependent trajectory
established and its associated idealisms and cultural frameworks remained uncompromised. Therefore, this critical juncture is characteristic of the ‘road not taken’ in the trajectory of health care reform.

In contextualising the institutional environment, the transition that occurred in British society, in terms of its prevailing cultural and social norms, came to significantly impact on the terrain of public policy. As stated previously, the sociological institutionalist approach places important emphasis on the parallelism that exists between the institutions that produces social policy and the cultural frameworks operating in society generally which in turn ‘frames’ the decision making process for policy actors. Thus, this cognitive element of sociological institutionalism focuses on ‘perceptions’ rather than ‘evaluations’ in the policymaking process (Berger and Luckmann, 1967; Peters, 2012; see chapter 3, section 3.4). In contemplating this in terms of the National Health Insurance Act, 1911, the cultural framework predominant in the social, political and economic spheres significantly conditioned the social policy initiated at this juncture.

The significance of this critical juncture also lies in the distinction that existed between the British and Irish ‘external’ environments during this period. In the British context, the ‘internal’ institutional environment of public policy was informed by: the orthodoxy of New-Liberalism; the industrialisation of society; the rise of the labour movement; and the extension of citizenship rights. While the cultural frameworks shaping public policy in the Irish context were the: political aspirations of Irish nationalism; conservative agrarian structures of society; the social and moral teachings of the Catholic Church; and the idealisms of private medical practice espoused by the Irish medical profession. Therefore, when evaluating the two distinctive cultural frames operating in the British and Irish context, it can be assuaged that due to the variance evident in the operating norms and value systems this led to the failure of the National Health Insurance Act, 1911 from becoming institutionalised in the terrain of Irish social provision (Clarke et al., 1987; Barrington, 1987; Adshead and Millar, 2003; Chapter 4, section 4.4).

The distinction between the ‘external’ environments reinforces further the theoretical premise of sociological institutionalism. As such, the policy outcome at this
critical juncture proves that for a model of social provision to be successfully internalised within the institutional fabric of a policymaking organisation, it must incorporate elements which are legitimated externally in society. Essentially, this reaffirms that when acknowledging the externally fixed institutions, which dictate the prevailing societal, political and economic values; this invariably leads to a reduction of turbulence and the maintenance of stability in the trajectory of policy initiation and implementation (Meyer and Rowan, 1991; see chapter 3, section 3.4).

As the National Health Insurance Act, 1911 mirrored the transition occurring in British society during this period it is palpable that the external exigencies present in the Irish context were not recognised at this critical juncture of social reform. Thus, the transition occurring during this period in British society proved to be the central precursor facilitating the emergence of this radical reform in social provision. As such, the National Health Insurance Act, 1911 was symbolic of an ideological ‘sea change’ occurring in Britain in that it exerted a challenge towards the political and economic orthodoxy of Classical Liberalism and laissez-faire capitalism. This transition in the political sphere came to be reflected in the emergence of the ideological perspective of ‘new’ liberalism (see chapter 4, section 4.4).

The National Health Insurance Act, 1911 thus represented a significant reassessment of the cultural attitudes to social provision. This is particularly evident regarding the redefinition that occurred in the relationship between the state and the citizens by way increased entitlement to welfare provision. Therefore, this critical juncture was reminiscent of an evolutionary cornerstone in shaping state responsibility in the arena of social provision. As such, this was symptomatic of a middle-way approach, within ‘new’ liberalism, between the idealisms of ‘individualism’ and ‘socialism’ in addressing social provision. This is exemplified in the initial interventions by the state in the provision of social security for its citizenry in the event of unemployment, sickness and incapacity to work. Under the stewardship of Lloyd George, the liberal reforms established a system that sought to provide reasonable protection against costs associated with child birth and the ravages of disease such as tuberculosis (Barrington, 1987; Thane, 1996; see chapter 4, section 4.4). This marked a significant shift towards a ‘social service state’ in that it enforced a ‘minimum floor’
principle which guaranteed a level of protection irrespective of the market value of a person’s worth or property. Furthermore, it also ensured that citizens were offered, without distinction of status or social class, the best standards of social services available. Therefore, this critical juncture demonstrates an extension of social citizenship rights which was to ultimately expand the scope of social provision to a level unprecedented in history (Briggs, 2006; see chapter 4, section 4.4).

From this contextualisation, the central reason for the National Health Insurance Act, 1911 becoming highly institutionalised in the arena of social provision was due to the absence of ‘turbulence’ in the external environment. As such, the consensus that existed in the policy and political sphere with that of the vested interests of the labour movement and trade unions effectively legitimated a cultural framework for economic and social reform of this kind. However, in the Irish case, this vision of extending social citizenship rights was not shared. The outright rejection of the National Health Insurance measure in this instance stemmed from the contestation of the vested interests present in Ireland during this period which were namely: the Irish Nationalist Party; the Catholic Hierarchy; and the Irish medical profession. By contrast to the external environment in Britain, it is evident that social reform measure was both overshadowed and superseded by the Irish political sphere’s focus on the National question and the objective of obtaining Home Rule and self-governance in Ireland (see chapter 4, section 4.4).

The ‘external’ environment in the Irish context was also subjected to the cultural frameworks legitimated by the Catholic Hierarchy and the Irish medical profession. In regards to the National Health Insurance Act, 1911, the stimulus behind the Catholic Church’s objection stemmed from a preconceived notion that the Irish economic landscape, which was largely agrarian in social class, was not suited to a model designed for a British urban and industrialised base. On the part of the Irish medical profession, their primary objection related to the fear that this social insurance reform measure was the stepping stone to the removal of ‘private medical practice’ and the creation of a ‘state medical service’. Furthermore, the dominant opinion in the ‘external’ environment during this period was to remodel the Poor Laws dispensary system with the view to achieving more efficiencies and favourable conditions. Therefore, within the theoretical
prism of sociological institutionalism, the rejection of the National Health Insurance policy measure in the Irish context was the result of the turbulence amounting from the conflicting cultural ideals and lack of legitimation in the ‘external’ environment (Meyer and Rowan, 1991; see chapter 3, section 3.4).

7.4.4 Mother and Child Scheme: the institutional rules of the game and refutation of the universal health insurance measures.

In a similar fashion to the National Health Insurance Act, 1911, the critical juncture surrounding the Mother and Child Scheme, 1947 has been depicted as a significant cornerstone in the evolution of social provision. As such, it was a period which saw the further embedment of cultural idealisms associated with the preservation of private practice and the effective institutionalisation of the means-testing/eligibility policy construct as a determinant to obtaining access to public health care services. Therefore, when assessing the Mother and Child Scheme as a period of significance in Irish history, it would be an understatement to view this critical juncture as being solely representative of a mere clash between Church and State (see chapter 4, section, 4.4). On the contrary, this period is particularly noteworthy in the context of this study as it brings to forefront the turbulent forces which led to the fall of the universal intent of this polity initiative and with it the demise of a political actor who defected from the informal norms and behavioural patterns embedded within the ‘internal’ institutional environment.

In this regard, the sociological institutionalist perspective provides an understanding of how the institutional legacies established at previous critical junctures (e.g. deserving and undeserving poor; individualism/self-help.) continued to influence the cultural norms and frames during this period. As such, these cultural norms and frames came to be reproduced by the social and moral ethos of the Catholic Church in tandem with the Irish medical professions idealisms concerning the maintaining of private practice. Hence, the vested interests in this context played a crucial role in shaping the ‘informal’ norms and codes of behaviour that governed the interactions of policy actors in determining social policy. The informal norms in this sense shaped the institutional rules of the game in the Irish health care arena and ultimately facilitated
institutional stability in continuing the path-dependent trajectory of public and private forms of health care provision.

In terms of deriving an understanding of the *institutional rules of the game* that came to be formulated through cultural norms and frames, this study has found that the conservative ethos of the Irish State and its contained political elite during the post-Irish independence period had a profound impact on social policy outcomes during this period. As such, it can be articulated that the scope of social provision proved to be limited and overshadowed by the aspirations of nationalism and the vulnerable state of the Irish economy. The instituting of nationalist ideals, however, proved to be the most significant in dominating the cultural framework during this period. In this regard, nationalism came to symbolise stability in an era characterised by insecurity which was caused by the Civil War (Breen et al., 1990; see chapter 4, section 4.5). Hence, the maintaining of stability proved to be a central concern in the ‘external’ institutional environment as a means of addressing the perceived ‘crisis of legitimacy’ in the governance structure of the newly founded state.

As a twin pillar to nationalism, the political orthodoxy of conservativism also proved to be instrumental in shaping the state’s approach to economic and social policy during this period. In this respect, it can be articulated that ‘continuity’ and/or ‘stability’ rather than ‘change’ proved to be a central part of the cultural framework influencing the institution of governance during this period (Lee, 1989, Breen et al., 1990; Ferriter, 2004; Garvin, 2004; see chapter 4, section 4.5).

From the outset, the cultural frame and value system informing public policy during the post-independence period was one which dictated that for the market economy to succeed, a reduction in welfare expenditure was necessitated. This adverse attitude towards welfare intervention was evidenced through the continuance of the Poor Laws institutional structure of social provision which effectively became an antecedent feature in post-independence Ireland. Essentially, this indicated a ‘individualist’ and *laissez-faire* sentiment in respect to economic and social policy during this period (Ferriter, 2004; Lee, 1989; Foster, 1988; see chapter 4, section 4.5).

The 1940’s decade, within this ‘external’ institutional framework, proved to be momentous in terms of attempting to introduce radical social reform. In part, the strive
for social reform was consistent with the revolutionary changes occurring elsewhere in Europe regarding the expansion of the welfare state and with it the extension of social citizenship rights – particularly in Britain through the publication of the Beveridge report. However, this was in stark contrast to the Irish experience where the idealisms of ‘individualism’ and ‘self-help’ remained to be dominant in the cultural frame and value system informing public policy during this period (see chapter 4, section 4.5).

Within the prism of sociological institutionalism theory, this study has found that the prevailing cultural norms and value system frameworks instilled by the Catholic Church had a significant impact on what conceptualised social provision during this period. As such, the Church had a clear vision in respect to the role of the state in society. Under this guise of welfare intervention, it was articulated that ‘negative’ interference, such as policing, was permissible. However, ‘positive’ state interference with respect to welfare provision was unacceptable. Therefore, ‘positive’ state interferences (e.g. the ideals of Beveridge report) represented a ‘logical deduction’ and an infringement of a citizen’s ‘natural right’ to fend for themselves (Powell, 1992; see chapter 4, section, 4.5). From the power of cultural frames and values possessed by external constituents, it becomes clear the limitations encountered by policy actors determining the scope of social provision.

Through the process of institutional isomorphism, it is evident that the prevailing cultural norms and attitudes which existed towards state intervention came to be transmitted in the internal environment of institutional policymaking (Meyer and Rowan, see chapter 3, section 3.4). In Figure 7.1 below, it is summarised from the study findings the prevailing conservative cultural frames which dominated the ‘external’ institutional environment during the *Mother and Child Scheme, 1947* and the *Health Act, 1957 (establishment of Voluntary Health Insurance)* critical junctures;
Figure 7.1: Institutional Isomorphism: *prevailing cultural and cognitive frames impacting on the internal institutional environment of the Irish health care system.*

The process of *institutional isomorphism* thus reinforces the theoretical premise that the triumph of an organisation, such as the Irish health care system, is dependent on the enhanced commitment of internal policy actors and external constituents (e.g. groups representing professional and societal vested interests) to the institutional organisation. Hence, demonstrating ‘awareness’ to external factors in society, such as cultural norms and conventions, has been found in this study to hold profound implications in securing support for the policy actions produced. Within the confines of this periodic timeframe, the political and societal ideals contained in the external institutional environment held significant ramifications in shaping the scope of the policy outcome at this juncture (Whyte, 1980; Lee, 1989; Foster, 1988; Barrington, 1987; Browne, 1986; and Powell, 1990; see chapter 4, section 4.5).
From this standpoint, the failure to adopt an alternative model of health care provision, such as social insurance systems of administration, stems from the ‘turbulence’ that would ensue in the external institutional environment. Therefore, the inability to introduce a principle of ‘universalism’, similar to the *National Health Insurance Act, 1911*, resonates with the fact that Browne’s Mother and Child Scheme clashed with the conservative cultural frameworks operating in Irish society at this time. As such, the Catholic hierarchy’s adverse attitude towards excessive forms of state intervention facilitated the maintenance of an individualist sentiment regarding welfare provision and the upholding of private medical practice in health service delivery (see chapter 4, section 4.5).

This reflected a resurgence of the cultural norms and conventions associated with the Poor Laws period, such as the epitomising of less state intervention and the advancement of ‘individualism’ and ‘self-help’ methods regarding welfare provision. Furthermore, this also led to the sanctification of the ‘family’ in the private sphere as being beyond the remit of state intervention. Hence, through exploring the dominant cultural frames and social values, this highlights the objective ideals that informed the policymaking process in the ‘internal’ institutional environment. Additionally, it also provides an understanding of how the social democratic and universal ideals of Noel Browne’s Mother and Child Scheme conflicted with the conservative cultural frames prevalent in society.

7.4.5 Institutional isomorphism and the Mother and Child Scheme, 1947: *the power of ‘cultural institutions’ and vested interests in the ‘external’ institutional environment.*

At this critical juncture, it is evident that the Catholic Church was beginning to intercept the field of social policy and in the process instituted its prevailing ideals and belief system. As such, the Church’s role in Irish society has been depicted as being symbolic of a guardian presiding over the prevailing social and cultural frameworks. Primarily through the education system, the Catholic Church successfully implanted its social teachings on not only the political elite but also the collective in society as a whole (Garvin, 2004; see chapter 4, section 4.5).
In terms of the cultural framework legitimated in the external environment, it is evident that the central remit for the Church was to prevent socialist idealisms, such as *freedom of consciousness*, from shaping the social and cultural psyche of Irish society during this period (Ferriter, 2004; Powell, 1992; Whyte, 1980; see chapter 4, section 4.5). In this sense, the Church cultivated its own conservative moral authority over the Irish people through state institutions acting as instruments. From the perspective of sociological institutionalism, it is evident that there were visible institutional isomorphic factors contained in the external institutional environment which ultimately shaped the behaviour of policy actors. Therefore, in analysing the Mother and Child Scheme, 1947 critical juncture through the prism of institutional isomorphism, this study has found that the ‘external’ institutional environment and the cultural norms and value system contained therein proved to hold a powerful influence in shaping the scope of social provision during this period.

The establishment of the Department of Health in 1947 also represented a pivotal development in facilitating institutional isomorphism to take place within the context of the initiation and implementation of health care policy. As such, the creation of an official government ‘department’ enabled the formation of an ‘internal’ institutional governance structure through which battles could be fought between policy actors and vested interests surrounding the character and future direction of health care provision in Ireland (see chapter 5, section 5.8). Therefore, the creation of an ‘internal’ institutional environment provided an ‘access point’ for external constituents. This in turn made the creation of health care policy particularly subject to prevailing cultural norms and conventions adhered to in society.

Thus far in this study’s analysis of the critical junctures, *resistance* rather than *change* forms as a central theme when characterising the evolution of Irish health care provision. In identifying the primary factors which led to the rejection of the Mother and Child Scheme, 1947, sociological institutionalists would posit that on the part of Noel Browne, as Minister for Health, there was a naivety and ignorance towards the prevailing ‘informal’ norms legitimated in the external institutional environment which customarily dictated the behaviour of policy actors. From this articulation then, it can be
assuaged how the objections of the Catholic Church to the Mother and Child Scheme came to be infiltrated into the internal institutional environment.

The Church’s resistance towards the Mother and Child Scheme was such that it proved contrary to Catholic social teaching. This is particularly pertinent regarding the Church’s position on the remit of the ‘family’ in society. In this regard, the Mother and Child Scheme represented a direct infringement on the rights of the family due to it being perceived as an excessive form of state intervention. However, the most disconcerting issue for the institution of the Catholic Church was the threat which the scheme posed in exposing women to matters of sexual education and family planning (Cooney, 1999; see chapter 4, section 4.5). Through the theoretical prism of sociological institutionalism, it is attributable that the scheme represented a fettered attempt at deconstructing the conservative moral ethos which represented the prevailing cultural and social conventional framework adhered to in society.

In ideological terms, the Catholic Church’s strict adherence to the principle of Quadrageissimo Anno, which encompassed the principle of subsidiarity, also proved to have an indelible impact on framing the ability of actors within the internal institutional environment of policymaking to extend the scope of social provision during this period. As this study has found, this principle effectively precluded the ideal of state intervention. From the outset, it was contended that the first recourse for welfare provision was not the responsibility of the state, but rather that of the family. The role of the state was limited to intervening in the event of a person becoming destitute or semi-destitute or in modern terms as a ‘first-aid’ measure. Hence, it is evident that a parallelism existed between the conservative vision of the Catholic Church with that of the cultural frame of classical liberalism and laissez-faire capitalism in operation during the Poor Laws era and in post-Irish independence. Essentially, this depicts a clear adherence to the concept of individual responsibility regarding familial welfare and a minimalist role for state intervention. Consequentially then, this conservative faction present in the external institutional environment leads to a realisation that the ‘liberal’ and ‘socialist’ leanings of the Mother and Child Scheme conflicted with the social norms and conventions utilised to frame decision makers thinking on this policy objective.
On the part of the Irish medical profession, the Mother and Child Scheme conflicted with the cultural ideals held by the organisation regarding the sustaining of private medical practice and professional autonomy. In this regard, the scheme represented an attempt to introduce a ‘state medical service’ and in the process provide free health care coverage to people who were viewed to be ‘non-necessitous’. Thus, the perceived ‘Fabian’ attributes of the scheme threatened the autonomy of the medical profession through the introduction of a public salaried service and the starvation of voluntary services in the favour of state services (see chapter 4, section 4.5). The dynamics of Mother and Child Scheme’s clash with the ‘external’ cultural frames of the Catholic Church and Medical Profession is more succinctly understood when analysing the policy outcome at this critical juncture through the theoretical framework of; the institutional rules of the game.

7.4.6 Institutional rules of the game: Institutional isomorphism and the role of ‘external’ assessment criterions in dictating the behaviour of policy actors within the ‘internal’ institutional environment.

As stated from the outset, the performance of Noel Browne as Minister for Health proved to be weakened considerably due to his inherent failure to interact or engage with those ‘informal’ elements present in the institutional environment at the highest level of government, the cabinet (Millar, 2003; see chapter 4, section 4.5). In turn, this highlights how the behaviour of internal participants within an institutional setting comes to be shaped and dictated by rules and norms that come to be internalised overtime (Immergut, 1998; Thelen and Steinmo, 1992; see chapter 3, section 3.2). Hence, when evaluating the policymaking process in terms of distinguishing between the ‘expressed’ and ‘real’ preferences of policy actors; Immergut (1998) ascertained that the ‘preferences’ and ‘decisions’ come to resemble the artefacts of the institutional environment (see chapter 3, section 3.2). Therefore, the institutional rules of the game, as a theoretical analogy, depicts how the informal ‘rules’ and ‘procedures’ present effectively distort the preferences of individuals considerably.

In contextualising the institutional rules of the game during the Mother and Child debacle, it is evident from the composition and cultural leanings of the members
of cabinet came to be represented in the adjudication of this policy initiative. From this standpoint, this study has found that the Catholic Church had its own emissaries, through their membership of the *Knights of Columbanus*, at cabinet level (see chapter 5, section 5.8). As such, the influence of the Catholic Church in this regard demonstrates how within the institutional confines of the Irish health care system and in an informal manner, the norms and conventions legitimated externally came to be reflected in the policy preferences of policy actors (Cooney, 1999; see chapter 4, section 4.5).

Through acknowledging the cultural significance of the *Knights of Columbanus* in dictating the behaviour of policy actors, it can be ascertained how Browne unanimously lost the confidence of his cabinet colleagues. Furthermore, the medical profession, in a similar fashion to the Catholic Church, also infiltrated in the passing of Browne’s Mother and Child Scheme through its sympathisers at the cabinet table (see chapter 4, section 4.5). Therefore, due to the cultural frameworks and conservative ‘scripts’ adhered to by the dominant cabinet ministers being at odds with the socialist leaning ideals of Browne in his attempt to provide a more ‘just’ health service, this provides a understanding of the power of institutional isomorphism in shaping policy outcomes. Moreover, it also reinforces the premise that the rejection of the Mother and Child Scheme is attributable to the fact that the prevailing cultural framework legitimated by the Catholic Church and the medical profession during this period was one which supported ‘individualism’/‘self-reliance’ and denounced the emergence of an expansionary welfare state similar to Great Britain under the guise of the Beveridge report. This is where the naivety of Browne comes to the fore, as he failed to recognise, through the informal norms and cultural conventions, the consequences which surmounted from the Church not sharing his vision of providing universal entitlement to health care. In that the Church, through its conservative vision, effectively sided with the rich against the poor through upholding the medical professions right to private practice (Browne, 1986; see chapter 4, section 4.5).

In assessing the dynamics of the ‘internal’ institutional environment through this institutionalist framework, it can be concluded that due to Browne’s clear conflict or non-compliance with the existing conservative norms and values implanted within the institutional fabric of the Irish health care system, this resulted in ‘uncertainty’ and
‘instability’ within the policy making arena (Hall and Taylor, 1996; Di Maggio and Powell, 1991; see chapter 3, section 3.4). Thus, the study has found that the primary reason for the fall of the Mother and Child Scheme, 1947 resonates with Browne’s failure to comply with the institutional rules of the game and secure legitimacy for the policy measure’s contained universal principles amongst external constituents.

This theoretical derivation is reinforced further through Zucker’s (1991 see chapter 3, section 3.4) analogy which stipulated that for an ‘act’ to become ‘institutionalised’; it must not be dependent on one individual policy actor. Rather, it must come to reflect the intersubjective world or taken-for-granted part of social reality within which policy actor operates. This contends that for a policy objective to succeed it must be reflective of the external institutional environment. Therefore, this reinforces the pertinence of securing support and legitimacy from external constituents as a means of ensuring institutional stability in the internal environment of policymaking.

7.4.7 Health Act, 1953 and Health Act, 1957: Institutional stability and the embedding of ‘eligibility of entitlement’ and ‘private medical practice’ in the Irish health care system.

By comparison to the Mother and Child Scheme, 1947, the passing of the Health Act, 1953 proved to be less turbulent and did not represent a threat to the path-dependent course of health care provision. While there was a prevalent intent by policy actors to extend health care services to the Irish population; the fact that the cultural norms and conventions which formed the institutional rules of the game were recognised this enabled both reform and stability in the health care arena. Thus, in stark contrast to Browne’s style of ministerial practice, Ryan was enabled to implement the Mother and Child Scheme, albeit a watered down version, through tactically engaging with the institutional rules of the game (see chapter 4, section 4.5).

Through both Ryan and de Valera’s engagement with the prevailing cultural norms and value system, they successfully gained legitimacy from the external constituent of the Catholic Church. As such, reform was achievable through being conciliatory to the concerns of the Catholic Hierarchy. This primarily occurred in response the governments removal of the ‘universal entitlement’ ethos of Browne’s
scheme and in introducing a criterion of eligibility which ensured that those within the upper income limit would be expected to pay for maternity and infant services. Therefore, this proves that through engaging with the *institutional rules of the game* this removes the potential for *institutional turbulence* and secures legitimacy from ‘external’ constituents for the policy produced by policy actors ‘internally’ within the institutional organisation.

From the *Voluntary Health Insurance Act, 1957* critical juncture, it is evident that the ideological precepts of ‘individualism’ and ‘self-help’ espoused during the Poor Laws era came to be sustained further through the establishment and endorsement of a private health insurance market to operate in Ireland. These idealisms are self-evident when critically analysing the political rhetoric during this period. As such, this study has found that the prevailing cultural sentiment was one not susceptible to the ideal of the state providing ‘free’ health care services. Rather, the establishment of VHI symbolised a tentative step towards encouraging Irish patients, both eligible and non-eligible to public hospital services, to engage with the private health insurance market in meeting their health care needs. Therefore, the development of the VHI in the evolution of health care reform signalled a shift towards a lesser rather than greater role for state intervention in the provision of this social good (O’Morain, 2007; see chapter 4, section 4.6).

Within this cultural framework then, a principle was beginning to evolve in which the delivery of health care to the upper income classes would be according to ‘ability to pay’ rather than on the ‘basis of medical need’. Therefore, from a sociological institutionalist perspective, the evolution and persistence of public and private forms of health care delivery is representative of the prevailing cultural norms in the ‘external’ institutional environment. Furthermore, it can be articulated within this framework that the ‘dualist’ idealism of social provision grew out of a strong desire by the medical profession to sustain private medical practice in Ireland. In the context of the *institutional rules of the game*, it is evident at this juncture that the ideals of the medical profession came to be realised through the positive rapport between T.F O’Higgins as Minister and this dominant vested interest group. Through O’Higgins conciliatory style of Ministerial leadership, the formation of voluntary health insurance symbolised the
granting of a solidified institutional voice to the medical profession (Barrington, 1987; see chapter 4, section 4.6). This to a significant extent proved to be pivotal in elevating the path-dependent policy trajectory of preserving private medical practice in Ireland. Hence, this study has found that in preserving the right to private medical practice in Ireland at this juncture, this copper fastened the source of the Irish medical professions power and influence in the institutional arena of health care provision. As the consecutive reforms demonstrate, the power of this vested interest in the institutional arena of health care provision came to be crystallised to a significant extent through the negotiations of the consultants contract (see chapter 5, section 5.5).

7.4.8 Contemporary structures in the Irish health care system: the resurrection of the Poor Laws principles in social provision.

When analysing the evolutionary critical junctures as a whole, it is evident that the dominant cultural sentiment dictating health care policy was one which emphasised on providing free public health care to the poorest in Irish society. Whilst the establishment of Voluntary Health Insurance cemented further the ideal that universal entitlement was not a prevailing policy option moving forward. In doing so, this demonstrated that the elevation of private practice was to be a dominant feature in health care reforms. Therefore, it can be summated that the Poor Law principles dictating social provision were consistently featuring at each consecutive reform of Irish health care provision.

This realisation is codified further in the Health Act, 1970 critical juncture. Despite reform proposals being put forward by opposition political parties which stemmed in the direction of introducing a universal/comprehensive health care service, the then Fianna Fáil government were adamant in continuing the established dualist system of the public-private mix in health care. This primarily occurred through reinforcing further in legislation the principle of eligibility of entitlement to public health care services. As such, the political rhetoric during this period was one which was not fuelled by ideology, cultural norms and value systems, or philosophical preconceptions as was the case in previous critical junctures. On the contrary, it was evident under the Ministerial leaderships of Mac Entee and subsequently Flanagan that the intention was not to introduce eligibility of entitlement beyond the poorest persons
in society. Therefore, the primary ‘cultural framework’ influencing policy outcomes in this context emphasised on sustaining the existing policy towards eligibility and concentrating excess resources on those with real need (Barrington, 1987; see chapter 4, section, 4.7).

The ineptitude towards introducing a comprehensive/universal health services stems from the framework of equality dictating policy during this period. As such, there was a clear shift in direction towards eradicating poverty as oppose to achieving outright equality in society. This framework correlates succinctly with the principle of eligibility codified at this juncture in that its primary motivation is to provide health care for the poorest/impoverished in society rather than achieve outright equality through a comprehensive health care service with universal access for all (see chapter 5, section 5.5 and 5.8).

Despite the opportunity to alter the scope and direction of social provision at the critical juncture surrounding the Health Act, 2004 and the establishment of the HSE, the status quo established in the previous junctures regarding access to health care services was maintained. As the policy constructs of ‘eligibility of entitlement to public health care’ and the ‘private health insurance system’ which effectively demarcated the population into the categories of public and private patient status on the basis of ability to pay remained to be a defining characteristic of the Irish health care model. Therefore, this critical juncture in sociological institutionalism terms symbolises the ‘finished product’ of a cultural framework and path-dependent policy trajectory which can be traced back to the Poor Laws era of social administration.

Within this contextualisation, it can be articulated that the successive Irish governments’ utilisation of the private health care market as a means-end to the provision of health care services highlights a political attitude that holds significant resonance with classical liberalism and the laissez-faire capitalist ideals adhered to during the Poor Laws era. Through upholding the ‘market’ as a mechanism in the demand and supply of health care services, this elevated the principle of delivering social goods according to the principle of ability to pay rather than on the basis of medical need. Hence, this reinforces further the ideals inherited from the past such as the cultural idealisms of individualism and self-help which espoused towards a lesser form
of state intervention and positioned a stronger onus of responsibility on citizens individually with respect to welfare provision.

In contemporary times, this study has found that the role of the state as the sole provider of social goods has also come to be challenged with the rise of the neo-liberalism political doctrine. The ideologue of neo-liberalism encapsulated an elevated role for the private sector and the practice of the individual engagement with the market place in the ‘purchasing of welfare goods’ (see chapter 4, section 4.8). In the context of health care provision, the neo-liberalism ideology came to be reflected in the policies of the Fianna Fáil and Progressive Democrat coalition government which oversaw the establishment of the HSE agency and the increased incentivising of the private sector in the delivery of health care services. Thus, there is a clear resurrection of the individualism and self-help cultural framework of the Poor Laws era. This had the effect in modern times of rewarding those with ‘ability to pay’ to swifter access above that of the lesser well off and vulnerable sectors in society who cannot afford to purchase health insurance. In a practical context, this cultural framework comes to fruition when critically analysing facets such as: two-tier system of a public-private mix in health care system; the operation of the consultants’ contract which sustains public and private forms of health care delivery; and the continued incentivising of the private sector through the provision of tax breaks for hospital construction and the co-location proposals (Wren, 2003, Burke, 2009; see chapter 4, section 4.8).

By comparison to the trajectory of welfare provision which predominated in the decades 1940’s – 90’s, the state in modern times is no longer expected to hold a monopolistic role in this arena. As such, this study has found that there is an evident re-routing back towards endorsing the Poor Law principles of ‘personal responsibility’ and ‘community responsibility’ as a means of upholding the welfare of the family. This depicts an environment in which there is a decentralisation of responsibility to the level of individuals and communities as a practical response to the contemporary fiscal challenges imposed on the state to fund social services (see chapter 5, section 5.10).
7.4.9 **Objective Four: Summary of main findings.**

Through the theoretical guise of sociological institutionalism, the findings above present an examination of how structural policy outcomes reached during critical moments in the evolution of Irish health care reform have conjoined in shaping the modern system of service delivery that we are most familiar with today. In particular, the theory of sociological institutionalism provides a succinct understanding of how the idealisms which govern the health service in modern times are a product of the continuous resurgence of the cultural norms and conventions of *individualism, self-help,* and *laissez-faire* capitalism established during the Poor Laws era. The continuity and refinement of this cultural framework was found in this study to provide ‘institutional stability’ in the course of health policymaking which in turn explains why alternative policy options such as ‘universal entitlement’ to health care services came to be subsided. Thus, the operation of this cultural framework held an enormous impact in both shaping and limiting the scope of health care provision. As such, the ‘internal’ institutional environment in responding to these legitimated ‘external’ frameworks at various critical junctures in Irish health care reform produced policy outcomes which effectively facilitated the coming to fruition of a discriminatory pattern in the treatment of public patients. This was reinforced through the continuous evolution of the policy precepts of ‘private medical practice’ and ‘eligibility of entitlement’.

7.5 **In terms of discursive institutionalism and the conceptual role of ideas in the trajectory of policymaking, how can the process of change be interpreted in Irish health care reform?**

From the sections above, the discussion centred on how the practice of institutional ‘continuity’ and ‘stability’ through the process of *path-dependent analysis* and the existence of *cultural frames* indelibly impact in shaping the scope of health care policy. Additionally, through the theoretical prisms of historical and sociological institutionalism, it was interpreted how ‘institutions’ constrain the actions of policy actors in the deliberations of policymaking. In this section, the focal point will be on how the process of ‘change’ can be explained in the policy trajectory of health care provision. From the study findings, it is evident that change, albeit in an incremental
sense, does feature as a facet in the health care arena. This comes to fruition when correlating the evolution of the Irish health care system with the theoretical framework of discursive institutionalism. Within this school of thought, there was an evident departure from the conception of change put forward by the traditional ‘new’ institutionalisms of historical, sociological and rational choice institutionalist perspectives. As such, the discursive institutionalist perspective represents a ‘dynamic’ as oppose to ‘static’ approach to institutional change. This primarily occurs through encompassing a more prominent role for ‘ideas’ and ‘discursive’ interaction in the policymaking arena.

Thus in this section, emphasis will be placed on how during specific moments in the Irish health care systems development, ‘change’ as a conceptual process came to be a viable facet in shaping the direction of social provision. It shall also comprehend, in discursive institutionalism terms, how ‘change’ came to be both adaptable and preventable at some of the critical junctures reviewed in this study. In this context, the theoretical precepts of coordinative and communicative discourse in conjunction with the process of policy framing provides some useful insights into explaining the conceptual process of change and the central features of those interactive discursive policy debates which shaped the development of the modern health care system.

In the latter part of this section, the discussion shall centre on the more contemporary health care reforms where policy change featured as a predominant theme. Within the context of the Health Act, 1970 and Health Act, 2004, it is going to be explored through the theoretical framework of ‘policy paradigms’ how the revolutionary administrative changes were facilitated during this period.

7.5.1 The ‘fourth’ new institutionalism: Discourse and the role of ideas in explaining policy change.

Within the discursive institutionalist school of thought, significant emphasis is placed on assessing the ability of a policy actor to think outside of the institutions which they operate, to communicate and deliberate about them, to persuade themselves as well as others to change their opinions on the institutions, and finally to take action to change them (Schmidt, 2010; see chapter 3, section 3.5). In contrast to the historical and
sociological institutionalist perspectives whereby the focus is on the institutions and its contained constraint mechanisms, discursive institutionalism elevates the significance of a policy actor’s behaviour/interactions in facilitating change and in shaping the scope or direction of an institutional organisation moving forward. This primarily occurs through the construction of discursive coalitions with the object of achieving reform in opposition to entrenched interests in the ‘coordinative’ policy sphere or through the process of informing and orientating the citizenry in the ‘communicative’ political sphere. Therefore, discursive institutionalism provides a modern slant on the practices associated with the institutional arena of policy administration. Furthermore, it also highlights how the delivery of policy ideals through a ‘persuasive discourse’ can facilitate for instance the winning of elections which in turn gives policy actors the mandate to implement their ideas (Schmidt, 2010; see chapter 3, section 3.5).

7.5.2 The significance of ideas in producing the policy discourse during the Poor Laws era.

From the outset, it is evident that the ideas which shape policy decisions through an interactive process of policy coordination and communication in discourse have been given prominence by the discursive institutionalist school of thought. In retrospect, the Poor Laws era represented a period in Irish history where economic, social and political ideals played a significant role in shaping the character and limitations of social provision moving forward. In the Irish case, the process of ‘change’ came to be characterised in subsequent reform initiatives as an attempt to realign away from the discourse which shaped social provision during this period. As such, there was a clear attempt by social reformers, such as Noel Browne during the Mother and Child Scheme juncture, to reposition the discourse of social provision away from the sentiments of ‘self-help’ and ‘individualism’ established during the Poor Laws era. Furthermore, there was a clear drive towards the development of a policy paradigm which reflected social democratic idealisms such as ‘universalism’ and ‘collective responsibility’. Therefore, the ideas which come to shape the policy paradigm have been depicted as a precursor in the wider process of facilitating change in the institutional environment of social provision.

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In terms of the theoretical framework through which ideas influence the institutional environment of policymaking, the behaviour of policy actors comes to be shaped by three distinct strands of belief systems: *world views*; *principled beliefs*; and *casual beliefs* (Goldstein and Keohane, 1993; chapter 3, section 3.5). During the Poor Laws era, the orthodoxy of classical liberalism formed the ‘world view’ of policy actors during this period. Hence, within the confines of the world view, the ideals of ‘individualism’, ‘self-help’ and the economic doctrine of ‘laissez-faire capitalism’ combined to form the ‘principled beliefs’ which reflected the normative idealisms distinguishing what is right from wrong and just from unjust within the policy making environment. The contemplation of the world views and principled beliefs combined demonstrates theoretically how the idealisms of classical liberalism came to be enshrined in social provision during this period. This is entrenched further through the ‘casual belief’ system, as it sustains the belief system through the authority derived from the shared consensus achieved from recognised elites in the ‘external’ and ‘internal’ institutional environments (Goldstein and Keohane, 1993; chapter 3, section 3.5).

Utilising this theoretical framework provides a concise understanding of the impetus behind the establishment of programmatic ideals (Schmidt, 2008; chapter 3, section 3.5) such as the workhouse system and the contained eligibility of entitlement criterions of *deserving* and *undeserving poor*. Thus, it can be articulated that the ‘minimalist’ programmatic ideals were established as both a solution to social problems during this period and designed to deter excessive reliance on the state in social provision. In turn, this also upheld the principled belief system of *individualism*, *self-help* and *natural forms of social assistance* operating in society. Through this theoretical derivation, it can be contemplated how political ideologies such as classical liberalism, and in more recent times neo-liberalism, come to be embedded in the institutional setting and reflected in social policy outcomes.

More significantly, it can be ascertained how the process of change occurs in the institutional environment. As such, this depicts that for a transition to occur in the policy course, a shift needs to emerge in the world views and principal beliefs that dictate the discursive paradigms and social policy produced. During critical moments in the evolution of the Irish health care system, ‘single policy actors’ have in their attempts to
introduce social reform sought to reorient the world views and concurrent principled beliefs as a means of extending Irish health care services. The process of change in this context can also be attributed to the interactive operation of communicative and coordinative discourse.

7.5.3 ‘Exogenous’ and ‘Endogenous’ institutional change: Interpreting change in the evolution of Irish health care system.

While static-continuity is a predominant facet within the traditional institutionalist theoretical framework, change to the ‘internal’ institutional environment is nevertheless depicted as occurring in response to an exogenous shock in the external environment (Schmidt, 2010, chapter 3, section 3.5). For instance, the establishment of the Irish Dispensary System, 1851 can be depicted as an ‘exogenous shock’ occurring following the Irish Famine. At this point, there was recognition that the world view of classical liberalism and its contained principle beliefs therein were no longer proficient in addressing social problems. This came to be recognised further during the National Health Insurance Act, 1911 critical juncture and the New Liberals reform agenda. Despite the rejection of this social measure in the Irish context, a comparative analysis of the factors which led to its successful passing in the United Kingdom and not in Ireland provides an understanding of an instance where the process of change can be both ‘achievable’ and ‘preventable’ through the framework of discursive institutionalism. As such, it is evident during this period there was a parallel existence of two ‘communicative’ and ‘coordinative’ discourses operating in both British and Irish societies during this period.

In the British context, there was a sea change in respect to the world views and principled beliefs which dictated social provision during that period. The emergence of the industrial revolution in parallel with the rise in electoral success of the Labour movement led to increasing demands for citizenship social rights. In turn, this highlights that an ‘endogenous’ process of change was occurring regarding the British state’s attitudes towards social provision. Hence, there was an evident shift from the classical liberalism tradition to the new-liberalism world view. This in effect symbolised a principled belief system which emphasised on an increased role for the state in welfare
intervention. Within this framework of social reform, a ‘communicative discourse’ also proved to be a pivotal precursor in facilitating change. The central reason for this rests on the premise that for political actors, in this regard the Liberal government, to maintain electoral success they must secure the support of the population through implementing social reform (see chapter 3, section 3.5).

As such, when faced with a changed societal and economic environment, the human behaviour of policy actors was to respond to that change through introducing in the ‘internal’ environment policies reflective of the transitions occurring ‘externally’ in society. In the British context, the industrial revolution and the rise of the labour movement forced policy actors to respond to this change through introducing social policies that addressed the social demands/ills symptomatic of a modernising society (e.g. providing protection in the event of unemployment, sickness, incapacity to work). This demonstrates that the process of change is not static as depicted in the traditional institutionalisms, of the historical and sociological institutionalist perspectives. On the contrary, the introduction of the National Health Insurance measure in the British context was reflective of a dynamic approach to change. This process is symbolised through the transition of political actors’ behaviour from the ideological principles of classical liberalism towards a ‘middle-way’ approach between the idealisms of individualism and socialism within the liberal dynasty (see chapter 4, section 4.4). Therefore, this dynamic approach to change to a large extent is representative of an interactive process encountered between political actors and the general public through a communicative discourse.

The appetite for change however was not equally demanded when analysing the Irish communicative discourse (Barrington, 1987; see chapter 4, section 4.4). In part this was due to the ‘world views’ and ‘principled belief systems’ present in Irish society being reflective of an economic and social landscape that was adverse to industrialisation and where agrarianism was rampant throughout the country. Therefore, it is evident that the communicative discourse present in Britain and the social reform measures derived in that process were in direct conflict with the public sentiment and idealisms present in Irish society during this period. As such, there was a parallel communicative discourse prevalent during this period that was distinctive to the
demands of both the Irish and British populace. By contrast to British society, the communicative discourse in Ireland was one which was dominated by the political interests of the Irish Party and its contained nationalist idealisms towards the achievement of ‘Home Rule’ from Westminster (Barrington, 1987; see chapter 4, section 4.4). Therefore, ‘change’ came to be prevented in the Irish context due to the social insurance measure being specifically designed to match the public sentiment of the British citizenry and the demands for an extension of social rights.

Within the coordinative discourse, there was also a visible distinction between the British and Irish policy spheres regarding the vested interests which influenced change in the social policy arena. In the British context, the institutional environment was one that was very conducive towards change. This was in part due to the joined up thinking between the vested interests in the political sphere, academia, and the labour movement/unions representing working class interests (Sullivan, 1996; Powell, 1986; see chapter 4, section 4.4). When compared to the coordinative discourse in the Irish context, it is evident that the collaboration between the Irish Party, the Catholic Church and the Irish medical proved to be ‘preventable’ in respect to facilitating change. This was primarily due to the social reform measures surmounting from the Liberal government at Westminster coming into direct conflict with the conservative ‘world views’ and ‘principled belief system’ that formed the backdrop in the political, social and economic landscape in Ireland during this period. In comparing the British and Irish communicative and coordinative process regarding this piece of social legislation, it is highlighted that for change to occur there must be consensus on the discursive ideals overseeing that process of transition.

7.5.4 The Mother and Child Scheme, 1947 and the establishment of Voluntary Health Insurance, 1957: analysing incremental change within a communicative and coordinative discursive process.

The decades surrounding the Mother and Child Scheme, 1947 and the Voluntary Health Insurance, 1957 junctures can be described as a period in which ‘incremental change’ was a dominant facet through the theoretical precepts of communicative and coordinative discourse. What is particularly interesting about this period in the context
of discursive institutionalism is how the communicative and coordinative process ‘prevented’ change in the context of the Mother and Child Scheme. Whilst change was ‘enabled’ in respect to the governmental decision to introduce an eligibility of entitlement criterion to public health care services (Health Act, 1953) and the enshrining of private practice through the establishment of Voluntary Health Insurance (Health Act, 1957).

As such, the central reason for change being prevented in this case of the Mother and Child Scheme rested on the premise that the social reform measure conflicted with the world views and principle belief systems dictating the discourse of social and economic ideals during this period. As stated above, the conceptualisation of social provision during this period was to a significant extent predominated by classical liberalism and laissez-faire ideational attitudes to social and economic issues. The discourse also espoused towards a conservative idealism in respect to social provision. Hence, Browne’s universal and somewhat social-democratic ethos of social reform conflicted with communicative and coordinative discourse prevalent in society during this period.

In terms of conceptualising this attempt at social reform within the confines of communicative discourse, it can be derived that Browne failed to proficiently engage in an interactive process to justify what would have been a momentous shift in the role of the state in respect to welfare intervention. This was reflected in Browne’s lack of support from both his cabinet colleagues and indeed the public at large (see chapter 4, section 4.5). Therefore, within the communicative discourse the failure of Browne to engage in an interactive process of active argumentation and bargaining resulted in ‘change’ being prevented (Schmidt, 2008; see chapter 3. Section 3.5). This process is essential as a means of facilitating a reorientation of the discourse practiced in an institutional environmental setting to one that reflected the appropriateness of the Mother and Child Scheme as a course of action in the Irish health care arena.

In a similar vein, the Mother and Child Scheme also faced contestation within the coordinative discourse. To a significant extent, this was based on the failure to achieve consensus due to the shear diversity of the discursive ideals possessed by the vested interests involved. In the first instance, there was bleak scope for consensus and
agreement due to the fact that Browne’s socialist idealisms and liberal thinking agenda were not compatible with the ‘world views’ and ‘principled belief systems’ dictated by the Catholic Church. The latter of which operated under a discourse that was conservative in ethos and adverse to what was perceived to be the uncontrollable change associated with policy initiatives devised under the guise of socialism and liberalism (e.g. fear of family planning advice being introduced) (Cooney, 1999; see chapter 4, section 4.5). On the part of the medical profession, as the second dominant vested interest, Browne’s social democratic idealisms inhibited consensus due to his reform measure being symbolic of a move towards a ‘state medical service’ or ‘socialised medicine’ which was in direct conflict with the discursive ideal of maintaining private practice. Therefore, through interpreting the ‘prevention’ of social reform in this respect, it can be articulated within the communicative and coordinative discourse that the failure to secure change rests with an incapacity to find a ‘middle ground’ regarding the prevailing discursive idealisms of socialism, conservatism and the idealism of private medicine.

By contrast to Browne’s attempt to extend health care provision to the Irish population, Ryan’s ministerial leadership appeared to be conducive in meeting the demands which arose within both the communicative and coordinative discourse. In this regard, Ryan achieved consensus in the interactive process with the public, cabinet colleagues in the communicative discourse and the Catholic Church as the dominant force in the coordinative discourse. One of the principle components which facilitated this process stems from the proficient reframing of policy ideas within a discursive policy paradigm. The process of framing social policies enables actors to make them politically acceptable. In theoretical terms, the practice of framing depicts a process whereby political elites strategically craft frames and utilise them to legitimise their policies to the public and to each other. Furthermore, the practice of policy framing also enables policy actors to conceal their motives from those they are trying to persuade (Schmidt, 1998; see chapter 3, section 3.5).

This is evident in the context of the Health Act, 1953 where de Valera as Taoiseach and Ryan as Minister for Health ‘framed’ their policy objective of extending free health care services to the Irish population through a discursive process that did not
infringe on the ideals of the Catholic Church. Therefore, through removing the ‘universal’ and ‘socialised’ idealisms from the original policy initiative and introducing an eligibility of entitlement criterion for the upper income groups’, consensus was achieved. Furthermore, the policy introduced was negotiated in an interactive coordinative discourse process which granted assurances to the Catholic hierarchy that the Irish state was not going to traverse down a liberal or socialist trajectory in respect to introducing policy change. Hence, this health care reform measure explains how ‘consensus’ can generate unity in respect to the discursive ideals operating within a given policy paradigm and this facilitate ‘incremental change’.

In a similar manner, the establishment of Voluntary Health Insurance under O’Higgins Ministerial term in health can be depicted as being on a comparable course of communicative and coordinative discourses. As denoted previously, (section 7.4.7 and chapter 4, section 4.6), O’Higgins conciliatory attitude towards the medical profession had the effect of elevating this vested interest as an institutional player in the coordinative discourse and the deliberations process on future policy ideals. This in turn explains how idealisms such as the preservation of private practice through the public-private mix remains to be a dominant feature on the discursive paradigm dictating the scope of health care provision.

Within the communicative discourse, it was prevalent that the process of framing also facilitated the establishment of voluntary health insurance. The political justification for the development of the health insurance market was secured on the basis that it provided coverage for 15 per cent of the population who were not eligible for public health care services (see chapter 4, section 4.6). Additionally in a discursive context, this policy outcome proved to be consistent with the conservative principled belief system of ‘individualism’, ‘self-help’ and ‘non-excessive forms of state intervention’. Therefore, from these two critical junctures it can be surmised that change, albeit incremental, can occur successfully in an endogenous fashion through actively ‘framing’ or ‘recasting’ policy ideals in a politically justified manner within the processes of communicative and coordinative discourse.
7.5.5 From the Health Boards to the establishment of the HSE: interpreting change through policy paradigmatic shifts and ideas in health care provision.

In a discursive institutionalist context, the Health Act, 1970 and the contained administrative reforms centred on the idealisms of ‘governance’ and ‘efficiencies’ in the delivery of health care services. This juncture in the reform process depicts both ‘exogenous’ and ‘endogenous’ shocks occurring regarding the discursive paradigm in health care provision. In this sense, the passing of the Health Act, 1970 and the centralisation of responsibilities for health care provision being diverted away from the local authorities is reflective of an ‘exogenous’ shock. This occurred in response to the growing financial issues arising at local level, a change in departmental attitudes and distrust in the capacity of local authorities to manage proficiently. There was also a recognition that the Department, as an administrative arm, was the most responsible body to deliberate over fiscal funding of the Irish health services (Barrington, 1987; chapter 4, section 4.7 and chapter 5, section 5.9).

With regards to endogenous change, through the process of coordinative discourse, significant influence came to be exerted by policy experts at this juncture of health care reform. This formed part of an interactive process between the political sphere and policy experts in creating a principled discourse of ‘efficiency’ and ‘improved governance structures’ which in turn came to dominate the policy paradigm during this period. Thus, the publication of the White Paper (1966) and the Fitzgerald Report (1967) proved to be significant in constraining the policy paradigm to focus exclusively on ideals pertinent to changing and reforming the governance structure (Barrington, 1987; chapter 4, section 4.7 and chapter 5, section 5.9).

From this standpoint, the discursive trajectory was one which focused on the public-private mix and efficiency principles. While the coordinative discourse was one not evidently concerned with idealisms associated with ‘equality’ in health care provision; ‘paradigmatic shifts’ and ‘incremental change’ were also features at this critical juncture. The shift in the governance discourse from a localised structure of policy implementation to a perceived more efficient regionalised health board structure was reflective of Hall’s theory of social learning and conception of policy change (1993;
chapter 3, section 3.5). This process of change occurs when there is a realisation that a once dominant policy paradigm is no longer functional.

When examining the establishment of the HSE agency, it is evident that discourse and ideas held a significant role in both facilitating institutional change and shaping public policy (Hall, 1993; Schmidt, 2008; Hay, 2001; chapter 3, section, 3.5 and Interview findings see chapter 5, section 5.10). Thus, this method of understanding the health policymaking process reflects at a comprehensive level how ideas come to be encompassed in the more general programs that underline policy initiatives. Essentially, the programs which come to be cast as paradigms reflect the organising principles which shape the direction and scope of social policy. As such, the function of the policy paradigm within this process of policy initiation and implementation is to provide ‘problem definitions’ which in turn limits the scope of possible solutions to the problems that the ideas aim to address (Schmidt, 2008; see chapter 3, section 3.5). In the context of contemporary health care provision, it is evident that the ideas contained in the policy paradigm are consistent of; efficiency through the principles of the New Public Management initiative and equity in the context of access to health care services on the basis of fairness. Furthermore, the political ideology which underscores this process as a world view is neo-liberalism (see chapter, 2, section 2.6 and chapter 4, section, 4.8).

Amongst these, the principles dominant in the policy paradigm are the achievement of efficiency and optimal outcomes. As such, it is evident that instead of achieving equality of outcome in health care policy, there was a clear focus on the attainment of efficiency with the specific intent of securing optimal ‘outputs’ in service delivery (see chapter 5, section 5.10). In this context, the doctrine of New Public Management has been depicted in the study findings as a predominant force in shaping the execution of public policy and in the governance structure of health care administration. This is particularly relevant when identifying strands of new public management in the institutional environment such as: the HSE as an autonomous agency; the focus on strategy; and the delivery of optimal outputs. Furthermore, ideals such as: accountability; affordability; and value for money in the services provided acted as central precursors occupying the mind-set of policy actors in the discursive
institutional environment. Therefore, this highlights theoretically how the ideational background through which policy actors interact with one another leads to the framing of policy ideals (Schmidt, 2008; see chapter 3, section 3.5).

In terms of contextualising the process of change in shaping the direction of the Irish health care system’s development, the theoretical construct of social learning provides insight into how policy actors reach a point of continuity or disbandment of a particular policy object and/or the concurrent paradigm therein. Therefore, the process of social learning provides an understanding of how a policy paradigm both comes to be sustained and enters a phase of change during evolutionary times of policy development (Hall, 1993; see chapter 3, section 3.5). Furthermore, the alternating variable of the social learning process occurs within Hall’s ‘three orders of change’ analogy. In the evolution of the Irish health care system, it is evident that the third order of change concerning the ‘overarching goals which guide policy’ did not occur upon the shift to the HSE model. This was primarily due to the objectives of public policy not diverting extensively away from those established through the Health Act, 1970. Rather, it was in the ‘first and ‘second’ order of change concerning the policy instruments and their specific settings used in achieving the overarching goals of public policy that the process of social learning is most prevalent. In this regard, the transition from the regionalised health board structure to the centralised HSE agency governance model marked the emergence of a new policy instrument in achieving the overarching goals of public policy.

Moreover, the removal of ‘operational responsibilities’ from the Department of Health to the autonomous HSE agency also marked a shift in the specific setting of the ‘policy instrument’ in the implementation of public policy. However, the most significant shift to occur in the techniques used to achieve the overarching policy outcomes was the application of the New Public Management initiative. As such, this signalled a transition in the administrative model through the emergence of private sector managerial techniques and the focus on ‘outputs’ rather than ‘inputs’ in respect to service delivery. This came to be symbolised further through the introduction into the Irish health policy environment concepts such as: strategic planning; value for money; performance measurement indicators; customer empowerment etc. As these are
techniques which only existed at a minimalist level prior to the establishment of the HSE (chapter 5, section 5.7).

Hence, it is evident from the study findings that Hall’s social learning analogy of ‘first and second order changes’ did occur in the public policy paradigm in terms of the techniques and policy instruments utilised to implement health care policy (1993; see chapter 3, section 3.5). However, due to the fact that the defining characteristics determining access to health care provision in Ireland such as: eligibility of entitlement; and the continuity of the public-private mix; remain intact, this demonstrates that ‘third order changes’ surrounding the overarching goals which guide public policy did not occur. A potential ‘third order change’ in this context would be the advancement of equality of access through an overarching goal of ‘universal entitlement’ for all Irish citizens to health care provision.

As such, it can be surmounted from the above discussion on the concept of ‘change’ that incremental rather than radical change is a dominant characteristic in successive health care reforms. In the context of the overarching variants of institutionalism theory, this is particularly reflective of the historical institutionalist interpretation of policy change where through its theoretical framework of layering it is explained how institutional reform or transition is representative of a ‘partial’ renegotiation of some aspects within its structural framework through the attachments of new elements to the existing ones (e.g. establishment of the health boards and HSE agency). Whilst the overarching goals of health care provision do not alter in the sense that eligibility of entitlement and the public-private mix remain intact (Peters, 2012; Thelen and Steinmo, 1992; see chapter 3, section 3.5). This can also be interpreted within the sociological institutionalist interpretation of change which dictates through its framework of sedimentation that an institution in redefining itself reflects actively on the past. Hence, the new institutional rules or policy instruments developed then come to be not far removed from those which previously existed (Peters, 2012; see chapter 3.5).
7.5.8 Objective Five: Summary of the main findings.

While ‘continuity’ and ‘institutional stability’ are central themes in successive health care reforms, the concept of ‘change’ is also a feature in this process. This study has found within a discursive institutionalist framework that change can occur primarily through engaging in a persuasive discourse within an institutional setting. Thus, within a communicative and coordinative discourse, change, such as the extending of eligibility of entitlement to health care services, is made possible through attaining consensus amongst the public, government members, opposition parties and most significantly the vested interests. This process is reflective of an endogenous approach to policy change whereby policy actors attempt to redefine the world views, principled beliefs system and institutional behavioural norms from within an institutional organisation. In reflecting on the administrative changes to occur in health service delivery in more recent times, the theoretical framework of policy paradigms and social learning have provided some useful insights; particularly Hall’s (1993) definition of the ‘three orders’ of change. In this context, this study has found that rather than altering the overarching goals of health care policy implementation (e.g. eligibility of entitlement; the public-private mix) which would constitute a third order change, the primary focus has been on changing the policy instruments. As such, this is empirically evident in the Irish case in that the health boards structure and the HSE did not alter the overarching goals/ethos of Irish health care provision. Rather the administrative reforms were reflective of instrumental changes regarding policy delivery. Therefore, this study argues that ‘incremental’ as oppose to ‘radical’ change is a dominant characteristic in health care reforms.

7.6 Conclusion.

Through the theoretical frameworks used, this study has found that a mixed-motives system of libertarian and egalitarian principles, which originated during the Poor Laws era, has been sustained in the developmental course of Irish social policy. In this regard, this study argues that the concepts of deserving and undeserving poor, individualism, self-help and laissez-faire market idealisms represented a predominant institutional legacy inherited from the Poor Laws period. These idealisms proved to be detrimental in shaping the character of health care provision as they later transformed to become
features which we most associate with health care provision in modern times such as: eligibility of entitlement; private health insurance; and incentivising of the private sector in health care delivery. One of the core reasons for the embedment of these structures and determinants of access and entitlement to health care provision was due to the fact that social policy in general was informed by and reflective of the prevailing cultural values and norms espoused in Irish society. Therefore, the precepts of ‘continuity’ and ‘institutional stability’ have been predominant themes in consecutive health care reforms.

The concept of ‘change’ has also featured as a dominant theme in health care reforms. As such, this study argues that preventable or achievable change is to a significant extent determined by a process of framing policy ideas and in gaining consensus amongst government members, the general public and the vested interests within a communicative and coordinative discourse. In the Irish case, this is particularly evident in the context of the Health Act, 1953 and the discursive deliberations which led to extension of eligibility of entitlement to public health care services. Furthermore, transitional change, in the context of policy paradigm shifts and the process of social learning, has also tended to focus on altering the instruments of public policy (e.g. health boards, HSE) rather than the overarching goals/ethos (e.g. eligibility of entitlement, public private mix) of health care policy delivery. Thus, the character of health care reforms in this context has tended to emphasise on incremental rather than radical change in the structures of health service delivery.
Chapter Eight

Conclusion

8.1 Introduction

This thesis explored the predominant ethos of ‘equality’ that governs modern policy conceptions of ‘access’ and ‘entitlement’ to health care provision in Ireland. While it is evident that no definition of equality, which is consistent with the dominant perspectives of philosophical egalitarian thinkers, can be found in policy documents or legislative Acts in the health care domain; this thesis argues, based on the secondary and interview data collected, that both libertarian and egalitarian idealisms are deeply rooted in the organisational structure of the Irish health service. In this context, it is argued that the ‘mixed-motives’ system that evolved overtime and which currently characterises contemporary health care provision has served to facilitate the emergence of inequalities and discriminative practices in terms of the access routes to health care services. To a significant extent, this is evident in the implantation overtime of policy practices such as: ‘two-tier access’; ‘public-private mix’; ‘eligibility of entitlement’ and consistent ‘incentivising of the private health care market’.

The existence of libertarian idealisms in health care practices has also served to institute the principle of delivering health care according to ability to pay rather than on the basis of medical need. While a paternalistic application of Rawls theory of social justice has been found in this study to exist in the provision of free-publicly funded health care to the most vulnerable and individuals in the lower income strata of society, through the GMS medical card, an outright egalitarian vision of universal access/entitlement across all socio-economic classes has been absent from successive health care reforms. Through the theoretical frameworks of institutionalism, this study has found that since the Poor Laws era, libertarian and egalitarian principles have been consistently embedded on a path-dependent trajectory of social legislation. Furthermore, this study argues that the resistance towards the introduction of a social democratic vision of universal access stems from prevailing cultural norms and cognitive frames which acted to both constrain the behaviour of policy actors and in the process
determine the direction of policy outcomes. Maintaining the status quo of the mixed-motives system in this sense and the avoidance of sharp ideological shifts in the ethos of health care provision has been argued in this thesis to represent a means of ensuring stability in the course of public policymaking. From this standpoint, the theoretical frameworks of this study has uncovered that the primary focal point in successive health care reforms has been on infrastructural development and the enhancement of efficiency in the governance structures overseeing health service delivery. Thus, from an egalitarian perspective, the primary emphasis in contemporary times has been on instilling ‘equity’ or a spirit of fairness, in respect to providing the lower income groups and those most need with access to health care services, rather than the achievement of equality of outcome through a universal system of entitlement to social provision.

In this chapter, conclusions are drawn from the overall thesis through a summarisation of the findings in light of the aims and objectives of this study. Additionally, this chapter discusses and considers recommendations for further research.

8.2 Summary of thesis, key research findings and drawn conclusions.

In Chapter One, the background context and rationale for this study was outlined and the core research aims and objectives were presented. As such, this chapter provided an overall introduction to the study and its central theoretical underpinnings. Through the theoretical frameworks adapted in this study, Equality, Efficiency/governance and Institutionalist perspectives, a deductive analysis was conducted to investigate the emphasis placed on instilling a philosophical framework of equality in successive health care reforms. In particular, this thesis explored the influence of equality in shaping core policy concepts such as access and entitlement to health care provision in Ireland. Also within this evolutionary context, this thesis examined the extent to which the instilment of an egalitarian ethos corresponded with the infrastructural development of the Irish health care system in efficiency and governance terms. In addition, this chapter provided an outline of the methodology applied in this thesis.

Chapter Two presented the literature relating to the theoretical frameworks of ‘equality’ and ‘efficiency’ which were relevant to this study. This chapter placed a focus
on how the scope of social policy and the concept welfare provision in modern capitalist societies are to a significant extent determined by the philosophical perspective on equality adhered to in the policymaking arena. In the context of this study, a focus was placed on the egalitarian interpretations stemming from: social citizenship rights; libertarianism; Rawls theory of social justice and ‘fair’ equality of opportunity; Sen’s egalitarian theory of equality of outcome/capability; Baker et al. theory of equality of condition and finally the concept of equity. Each perspective has been found to present divergent ‘prescriptions’ for the structure of society and the shaping of social policy outcomes in egalitarian terms. This is particularly pertinent in the context of health care provision where it was found that each egalitarian framework prescribes divergent policy outcomes in terms of health service delivery. For instance, in a health care system organised according to a Rawlsian conception of social justice and ‘fair’ equality of opportunity, an emphasis is placed on delivering health care to those with the worse health status. This is in contrast to a health care system adapting Sen’s egalitarian framework which would aim to achieve equality in health across all individuals in society.

In the latter part of chapter two, a focus was placed on exploring the principles of ‘efficiency’ influencing the organisation of health care through a review of the literature surrounding the concepts of governance, the New Public Management Initiative (NPM) and the Strategic Management Initiative (SMI). From this standpoint, it is evident that the governance principles of NPM/SMI have had an indelible influence in shaping the modes of health service delivery in recent decades.

Chapter Three reviewed the literature surrounding the theory of ‘new’ institutionalism and its application to the policy process. In particular, this study contemplated how the theoretical cores of: Historical Institutionalism, Sociological Institutionalism and Discursive Institutionalism can be utilised to facilitate an understanding of how modern conceptions of ‘equality’ and ‘efficiency’ came to be embedded in the Irish policy making field of health care. The Historical Institutionalist school of thought provides an analysis of the policymaking process and the shaping of policy outcomes through a theoretical focus on the informal ‘rules’ and ‘procedures’ which are thought to structure the conduct and behaviour of internal actors within an
institutional environment of policymaking. Furthermore, with the theoretical constructs of *path-dependent analysis* and *critical junctures* historical institutionalists provide a succinct framework for understanding the process of institutional persistence and how particular policy trajectories are sustained over time. In the context of path-dependent analysis, theorists have demonstrated how patterned policy trajectories occur when policies constructed at a formative stage in an institution’s existence come to be ‘locked-in’ and continuously reproduced. Thus, persistence is explained through the existence of ‘self-reinforcing’ processes in the policymaking sphere. The construct of the *critical juncture* illustrates the process of institutional persistence through an emphasis being placed on the selection of particular policy outcomes. In this context, it is demonstrated that once a policy option is chosen it becomes progressively difficult to alter into the future.

The *sociological institutionalist* perspective, in a similar fashion to historical institutionalism, accounts for the process of institutional stability and persistence in the field of public policymaking. This theoretical perspective sheds some interesting insights into examining how the ‘internal’ structures of the policymaking environment are subjected to prevailing cultural norms – normative and cognitive, informal and formal – which ultimately act to constrain the behaviour of actors in the initiation of public policy. In particular, the theoretical principle of *institutional isomorphism* articulates how the ‘external’ environment of society and its contained cultural norms and value systems proves to be crucial in shaping the norms and values systems adhered to in the ‘internal’ policymaking environment which in turn shapes the policy outcomes produced.

In contrast to the historical and sociological institutionalists’ schools of thought and their theorists focus on ‘exogenous’ or ‘radical change’ in offsetting a policy trajectory, the *discursive institutionalists* perspective provides an endogenous conception of institutional change. Thus, discursive institutionalists place significant emphasis on the role of ‘ideas’ and ‘discourse’ in the shaping of public policy. This occurs within the interactive processes of *communicative* and *coordinative* discourses. Notwithstanding the endogenous approach to change adapted by discursive institutionalist theorists, historical institutionalist theorists such as Hall (1986) have
provided a succinct theoretical framework for analysing incremental change in the policymaking arena. This process is accounted for through analysing the occurrence of policy paradigm shifts and social learning in the trajectory of policymaking.

Through the adaption of the historical institutionalist precept of the ‘critical juncture’, Chapter Four chronicled core moments in the development of the Irish health care system which ultimately shaped the contemporary structures of access/entitlement and governance in health service delivery. The critical junctures of significance in this study were: the Irish Poor Laws; the establishment of the Dispensary System, 1851; Mother and Child Scheme, 1947; the establishment of Voluntary Health Insurance (VHI), 1957; Health Act, 1970 and Health Act, 2004/Establishment of the Health Service Executive (HSE) Agency.

The initial critical juncture surrounding the Poor Laws era of social legislation has been found in this study to have had an enormous impact in shaping the character of social provision moving forward. This is particularly pertinent when analysing the policy precepts of deserving and undeserving poor which determined access to state funded social provision during this period. As such, these precepts later transformed to become the modern policy constructs of ‘eligibility of entitlement’ and ‘means-testing criterions’ as determinants to accessing public health care provision. Furthermore, the libertarian ideals of: ‘individualism’; ‘non-state intervention’; and the ‘upholding of the free market’ associated with the Poor Laws era also proved to be indelible in shaping consecutive health care reforms. This is particularly evident in respect to the: organisational ethos of the Irish health insurance market; the ‘public-private mix’; and the continuous incentivising of the private health care sector in the delivery of health care services. Thus, it is apparent that the legacy of the Poor Laws era has served to facilitate libertarian and egalitarian forms of social provision to come to fruition in health care provision. In egalitarian terms, the critical junctures, in particular the National Health Insurance Act, 1911 and the Mother and Child Scheme, 1947, demonstrate that successive reforms in this social arena have persistently resisted the introduction of a health care system founded on ‘universal entitlement’. Thus, the ethos of delivering health care services according to ability to pay rather than on the basis of medical need has featured as a core theme in this narrative of health care reforms.
Chapter Five presented the interview findings relating to the viewpoints of key stakeholders in the Irish health policy domain. The findings reflected on participants perspectives on: the theory and practice of equality in health service provision; the evolution of the Irish health care system and the influence of vested interests in shaping this process; and the administrative and governance structure of the Irish health service in efficiency terms. The findings also presented the participants reflections on the concepts of ‘equality’ and ‘efficiency’ in respect to the orientation of health policymaking following the enactments of the Health Acts, 1970 and 2004.

Chapter Six and Seven formed the discussion chapters in this thesis. As such, the findings presented in chapters four and five were discussed in light of the literature presented in chapters two and three and the core research objectives of this study. In Chapter Six, the primary emphasis was on objectives one and two of this study pertaining to the concepts and practice of ‘equality’ and ‘efficiency’ in health service delivery. The conclusive findings from objective one reveal that the structures of the Irish health care system encompasses both a Rawlsian conception of social justice and fair equality of opportunity and a Libertarian ethos in respect to service delivery.

Essentially, the ‘mixed-motives’ system which evolved in this context has led to a limited ethos of equality emerging in the Irish health care system. As such, the concept of equality invoked in the policymaking environment of the Irish health care system has focused on ensuring that the ‘least-well off’ and most ‘vulnerable’ in our society are afforded basic health care services. In policy practice, the construct of ‘eligibility of entitlement’, through the GMS medical card, represents a purposeful or targeted vision of equality. This is consistent with a Rawlsian conception of social justice which aimed to institute a baseline of impoverishment in which no individual in society would fall beneath. In many respects, this vision of equality has been found to correlate in recent times with a focus by policy actors being placed on equity and the instilment of a spirit of fairness in health care provision. This contrasts greatly with the philosophical perspectives reviewed in this study which advocate a more outright vision of equality, such as Sen’s ‘equality of outcome/capability’ framework. In this context, a primary focus is emphasised on ‘equality of access and entitlement’ through a universal health care framework for all citizens in society irrespective of income.
On the contrary, within the structures of health care delivery established by the Health Acts, 1970 and 2004, an ‘implicit’ rather than ‘explicit’ vision of equality is thought to exist in the Irish health care system. Under this framework, equality is believed to be evident in the achievement of both access for the lower-income strata and most vulnerable in society through the achievement of ‘optimal patient outcomes’ in the arena of health care delivery.

However, this study concludes that the existence of the ‘eligibility of entitlement’ policy construct in correlation with the libertarian practices, of the health care insurance market and the public-private mix, has acted to exacerbate inequality and discriminative practices in health service provision. In turn, this has laminated, in the health policy discourse, an ethos of delivering health care on the basis of medical need rather than on the principle of ability to pay.

The ultimate findings from objective two of this thesis asserts that in analysing the more recent health care reforms, Health Acts, 1970 and 2004, it can be concluded that the policy object of achieving ‘efficiency’ in the governance and infrastructure of health service delivery has far outweighed the desire to instil an egalitarian ethos in the Irish health service. In terms of the governance structure overseeing the administration of service delivery, it is evident that the doctrine of New Public Management (NPM) has been a dominant force in shaping the contemporary reform agenda of the Irish health services. In particular, the application of NPM is evident through the introduction of the Strategic Management Initiative (SMI) and in the establishment of the Health Service Executive (HSE) Agency. Within this contextual framework, efficiencies in the governance of health service delivery is believed to be evident in the reorienting of the public sector ethos from ‘inputs’ to ‘outputs’ in the determination of policy outcomes and also in the introduction of the administrative practices of: strategizing; performance measurements; and standards. The establishment of the HSE in many respects was the epitome of this administrative reform process, as it executed into the governance framework the principles of: accountability; efficiency; standardisation; consistency and coherence in service delivery. In parallel with these principles, the centralised entity of the HSE instilled notable efficiencies by comparison to what existed under the previous health boards administrative structure.
However, when critically assessing the application of the NPM principles in practice, the findings conclude that significant inefficiencies have been born since the inception of the HSE. The most notable inefficiency to emerge has been the failure to apply a core principle of NPM, the process of *rationalisation*, following the establishment of the HSE agency. Through the involvement of the Trade Unions and the political haste at which the HSE was established, this led to the growth of a bureaucratic intensive organisation with an excessive managerial outlook. Furthermore, the ‘policy’ and ‘operations’ divide regarding the roles and responsibilities of the Department of Health and the HSE agency has acted to violate democratic accountability and parliamentary accountability in respect to the delivery of health care services. Additionally, this divide in the administration of health care services has also served to diminish the role of the ‘Department’ in matters of policy execution. In terms of public perceptions on the inefficiencies to emerge in recent decades, the *corporate branding* of the HSE has facilitated a negative portrayal, through the media, on the effectiveness of the organisation in the arena of health care service delivery.

*Chapter Seven*, through the theoretical frameworks of institutionalism theory, emphasised on the trajectory of the policymaking process in the Irish health care arena in the context of the overarching principles of ‘equality’ and ‘efficiency’. In particular, *objectives three, four* and *five* examine specific attributes in this process which were namely: the precepts of ‘continuity’ and ‘institutional legacies’ in both the structuring of policy outcomes and shaping the scope of welfare provision; the role of cognitive, normative and regulative structures that provide institutional stability; and the role of ideas and discourse in facilitating institutional change in the policy trajectory of the Irish health care system. Thus, the concepts of ‘continuity’, ‘institutional stability’ and ‘change’ were core themes discussed in the latter objectives of this study.

In *objective three*, the study concludes through the theoretical variant of historical institutionalism, that the attributes which contribute to contemporary inequalities and discriminative practices, in respect to access and entitlement to health care services, are part of a *path-dependent* process which have been consistently ‘self-reinforced’ and ‘regenerated’ in the subsequent social policy reforms in health care following the Poor Laws era. In particular, the institutional reproduction of this path-
dependent policy trajectory has acted as an operant that preserves the idealisms which informed applied social policy practices during the Poor Laws era. These idealisms were namely: the ideological predisposition of individual responsibility; self-reliance; and the policy construct of eligibility of entitlement. From this contextual framework, this study can conclude that the object in successive social reforms has not been to instil an outright egalitarian premise under the guise of universal health care entitlement but rather the strive of policy reformers has been to protect the poorest in society through public intervention while the able-bodied continue to fend for themselves. Therefore, the sentiment in which the Irish health care system was founded, in this instance the mixed-motives idealisms of libertarian and egalitarian practices, provides an understanding of how the private health care sector has continued to thrive with the passing of consecutive reforms whilst principles surrounding universal health care entitlement has been consistently whitewashed.

The findings from objective four surrounded the theoretical framework of sociological institutionalism and a contemplation of how the idealisms which influences the structure of Irish health care system in contemporary times are a product of the continuous resurgence of the cultural norms and conventions of: individualism; self-help; and laissez-faire capitalism established during the Poor Laws era. As such, the continuity and persistent refinement of this cultural framework acted to facilitate institutional stability in the course of introducing consecutive health care reforms. From this standpoint, the operation cultural frameworks, such as conservative and neo-liberal outlooks, have proven to hold an enormous impact in both shaping and limiting the scope of health service provision in egalitarian terms. In this context, the ‘internal’ institutional environment of policy making, in responding to legitimated ‘external’ frameworks (such as Catholic social teaching) at various critical junctures, has produced policy outcomes which enabled discriminatory patterns in the treatment of public and private patients come to fruition.

From objectives three and four, the concept of continuity and institutional stability proved to be a central theme in the policy trajectory of health care reform. However, as objective five contends, the concept of change has also featured in this process. Through the theoretical lens of discursive institutionalism, this study concludes
that change can occur through engagement within a *persuasive discourse* in an institutional setting. Within a ‘communicative’ and ‘coordinative’ discourse, change is thought to be facilitated through achieving consensus amongst the public, government members, opposition parties and most significantly the vested interests. This process is representative of an *endogenous* approach to change whereby policy actors attempt to alter the policy course through refining the ‘world views’, ‘principled beliefs system’ and ‘institutional behavioural norms’ that are embedded within the institutional policymaking environment.

When contextualising the administrative changes to occur in health service delivery in recent decades, Hall’s (1993) theorisation of policy paradigms and social learning in conjunction with his derivation of the ‘three orders of change’ provided some interesting conclusions. As such, this study has found that rather than altering the overarching goals of health care policy implementation (such as eligibility of entitlement and the public-private mix of two-tier access) which would constitute a *third order change*, the primary emphasis has been on altering the instruments of policy implementation. In this sense, the establishment of the Health Boards and HSE administrative structures cannot be interpreted as altering the overarching goals/ethos of health care provision but rather were representative of an instrumental change to service delivery. Hence, this study argues that *incremental* rather than *radical* change is a dominant characteristic in the trajectory of health care reform.

For a radical change to occur, through for instance the introduction of Universal entitlement, this thesis concludes that an ‘exogenous’ form of change is necessitated which would be reflective of a process in which the institutional organisation of policymaking is responding to wider changes/demands stemming from the external environment of society generally.
8.3 Recommendations for future research.

In this section I discuss recommendations for further research. As such, emphasis will be placed on the core theoretical frameworks of this study and the data collection processes.

- This thesis emphasised on mapping out the development of the Irish health care system in terms of equality and efficiency principles and within the framework of the ‘new’ institutionalist perspective of: Historical, Sociological; and Discursive Institutionalisms. In this context, I feel that the vigour of Institutionalism as a theoretical approach to analysing the trajectory of health policymaking could be explored further through a comparative analysis of differing health care systems. As Immergut (1992) has demonstrated in her comparative study of the health care reforms in France, Sweden and Switzerland, an enriched account can be derived when applying institutionalist analysis to differential policymaking environments. In utilising Esping Andersons (1990) ‘Three Worlds of Welfare’ as a theoretical framework, I believe that a thorough understanding of the institutional dynamics to health care policymaking would emerge also from a comparative study of the Irish case to that of a health care system within a contrasting welfare regime and ‘institutional policymaking’ context. For instance, it would be interesting to compare the Irish approach to social provision, which has been depicted as a ‘corporatist-statist’ welfare regime within Andersen’s typology (see Adshead and Millar, 2003), to that of a country within the ‘social democratic’ (i.e. Sweden) or liberal (i.e. United States of America) welfare typology in terms of the empirical research themes explored in this study.

- The Sociological Institutionalist perspective, through the process of institutional isomorphism, provided a thorough understanding in this study of how prevailing ‘cultural norms’ and ‘social conventions’ inherent in society can directly constrain the policymaking behaviour of actors operating in the ‘internal’ institutional environment and in the process shape the policy outcomes produced. For future research, it is my belief that an examination of the prevailing ‘external’ cultural norms and value systems in society could be
applied through utilising a ‘mixed methods’ approach whereby a focus would be placed on the conducting of quantitative surveys; qualitative interviews; and focus group interviews with the general public, service users and key stakeholders in the Irish health care system. This, in my belief, would provide a vigorous data set on the cultural norms and social attitudes towards core concepts relevant to this research area such as: equality; access/entitlement; treatment on the basis of ability to pay/on the basis of medical need; and the upholding of libertarian/egalitarian principles in health care delivery. In turn, this would in my belief strengthen sociological institutionalism further as a theoretical framework in understanding how cultural influences and social norms constrain the ‘internal’ institutional environment of policymaking in the Irish health care system.

- In terms of assessing inequality in respect to access and entitlement to health care provision, it is my view that future research could be conducted in the empirical analysis of discriminative practices operating in the structures of the Irish health care system. This would involve interviewing key professionals on the frontline of health service delivery (i.e. nurses and Non Consultant Hospital Doctors in terms of operational practices) and patients/general public (i.e. in terms of patient satisfaction and experiences). This form of empirical analysis could also be applied to developing a comprehensive analysis of the principled ‘efficiencies’ delivered in the Irish health care system in contemporary times.

### 8.4 Conclusion

From this research conducted, I would like to suggest that the theoretical framework incorporated in this deductive analysis of the Irish health care system in egalitarian and efficiency terms be adapted for other significant spheres in Irish social policy. Most notably, I believe that an institutionalist framework would provide an enriched examination of the policymaking environments in the fields of: education policy, housing policy and social protection. Furthermore, in the domain of foreign policy it is my view that the institutionalist perspective – with its particular focus on historical
processes, role of institutional actors, discourse and ideas – would provide both an interesting and critical assessment of Ireland’s relationship with the European Union (EU). As such, some interesting insights could be derived in respect to the Irish approach in its interaction with prevailing supranational institutions within the EU on matters relating to the initiation and implementation of EU policy and also the impact on domestic policymaking in Ireland.

In concluding this thesis, the study of the Irish health care system through the theoretical lens of: equality; efficiency; and institutionalism have provided comprehensive insights into understanding the point of origin and continuity of the features which characterises the Irish health care system in recent times. In particular, the theory of institutionalism represents a succinct framework for critically examining the institutional environment which oversees both the development and continuity of public policy overtime. As such, the theoretical constructs adapted from the historical, sociological and discursive institutionalists schools of thought have provided an inclusive account of how the contemporary health care system is the product of a policy trajectory characterised by the concepts of continuity, institutional stability and incremental change.
Bibliography


Appendix I

Interview Schedule

1. One of the central tenets of social policy is ‘equality’. What is your understanding of ‘equality’?
2. In your opinion, what form of equality best characterises the Irish health care system?
3. How has that form of ‘equality’ evolved over time?
4. In considering the evolution of the Irish health care system, what are the periods of greatest significance in that development?
5. Has ‘equality’ been a central issue in successive health care reforms?
6. In the context of the Health Act of 1970 and the most recent Health Act of 2004 how much concern was there for ‘equality’?
7. What is the status of ‘equality’ as a concept in the Health Act of 1970 and the Health Act of 2004?
8. What principles of ‘equality’ have guided policymakers in the drafting of health policy in Ireland?

1. In your opinion, what was the impetus for policy actors when enacting the Health Act of 1970?
2. What in your view were the central issues/concerns which led to the establishment of the Health Service Executive Agency (HSE) formally in 2005?
3. Does the existence of the HSE advance or hinder the cause of ensuring greater efficiency in the Irish health care system?
4. Does the existence of the HSE advance or hinder the cause of ensuring greater equality in the Irish health care system?
1. What are your views on the ‘welfare state’ and ‘the role of the state’ in social provision?

2. In the context of the recent economic turbulence and introduction of fiscal austerity measures, how would you characterise the nature of social provision in Ireland today?

3. Has that characterisation been consistent overtime or evolved considerably?

4. In your opinion, what are the main issues which preoccupy the minds of policymakers in Ireland?
Appendix II

Categorisation of Interview Participants, their function/role and an overview of data collected.

<table>
<thead>
<tr>
<th>Interview Participant Group</th>
<th>Function.</th>
<th>Overview of Data Collected.</th>
</tr>
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<tbody>
<tr>
<td>Political Actors.</td>
<td>Public Representatives – past and present; Former Ministers for Health;</td>
<td>From a political perspective, the data collected reflected on:</td>
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<tr>
<td></td>
<td>Opposition Spokespersons for Health.</td>
<td>• The meaning of equality in social provision.</td>
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<td></td>
<td></td>
<td>• The overarching goals of health care policy in theory and practice.</td>
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<td></td>
<td></td>
<td>• The historical evolution of social provision in the context of health care provision</td>
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<td></td>
<td>and the dominant influences/vested interests impacting on its development.</td>
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<td></td>
<td></td>
<td>• Core debates or policy issues surrounding access and entitlement to health care</td>
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<td>provision.</td>
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<td></td>
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<td>• The performance of the Irish health care system in terms of:</td>
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<td></td>
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<td>equality of access and entitlement; and efficiency in administrative governance and</td>
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<td>policy outcomes.</td>
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<td></td>
<td></td>
<td>• The core barriers faced by the political sphere regarding the instilment of egalitarian</td>
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<td></td>
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<td>and efficiency principles in the Irish health care system.</td>
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<tr>
<td></td>
<td></td>
<td>• The role of the state in social provision and the future of the welfare state model.</td>
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</table>
| Administrative Actors – Civil Service and Health Service Executive. | Secretary Generals and Assistant Secretary Generals in Department of Health – past and present – and National and Regional Directors in the Health Service Executive Agency. | From the administrative sphere of civil service and HSE, the data collected reflected on:

- The goals of health policy implementation in terms of equality (access and entitlement) and efficiency (administrative governance, service delivery and policy outcomes).
- Characterising the distinction between a policy goal of equality with that of equity and the implications of both egalitarian perspectives for policy practices and outcomes in health service delivery.
- The performance of Irish health care system in recent decades – observational assessments of equality (i.e. access and entitlement) and efficiency (administrative governance – efficient and inefficient) principles in theory and practice in recent decades. |

| Policy Advisors. | Policy Advisors to consecutive Ministers for Health and Political Parties. | The data in this instance provided an overview of the Irish health care system from both a political and administrative perspective. The data reflected:

- The overarching goals of health policy initiation and implementation in terms of equality (access and entitlement) and efficiency (administrative governance and structures of service delivery).
- An overview of the Irish health policymaking environment and the intricacies associated with engaging with core vested interests in the initiation and implementation of health care policy (for instance gaining |
In the sphere of academia and health policy analysis, the data collected provided a balanced and coherent account of the structures of social provision in Irish health care and core debates surrounding:

- The theorisation of social equality/inequality and social citizenship in modern capitalist societies and the implications regarding access and entitlement to health service provision.
- The characterisation and root causes of social inequality in terms of policy practices in the Irish health care domain.
- Administrative governance and the structures of the Irish health care system in terms of efficiency and inefficiency in policy practices associated with service delivery.