Irish healthcare between the Sláintecare *reform and the Recovery and Resilience Plan*[*]

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ABSTRACT:
This paper provides a comprehensive overview of the Irish healthcare system vis-à-vis the response to the COVID-19 pandemic and the adoption of the Recovery and Resilience Plan. The study examines the constitutional context of healthcare policy in Ireland and the ongoing debate on healthcare reform and the Sláintecare implementation. The Irish Recovery and Resilience Plan and its implications for healthcare are also analyzed in an attempt to situate the Irish response to the pandemic within the general trends in the European area.

1. The Irish healthcare system: "a canary in the coal mine"?

Within the general context of the Next Generation EU Recovery Plan, this paper aims to analyse Ireland's normative response to the pandemic in the area of healthcare organization and public health services. As is well known, the Next Generation EU plan, launched

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in July 2020, represents a historic initiative to address the economic and social challenges posed by the unprecedented COVID-19 pandemic crisis. The plan aimed to support EU Member States and to help them recover from the economic impact through a €750 billion recovery package. The package consists in €390 billion in grants and €360 billion in loans to Member States.[1]

The funds were intended to support healthcare systems severely affected by the health emergency, but also to invest in sustainable initiatives, promote economic resilience and the digitalization of public services, while addressing social and economic disparities exacerbated by the pandemic.[2] Indeed, the impact of the pandemic on all sectors of the public sphere and the response to the health emergency constituted a major stress test for the resilience of constitutional systems. This proved to be a difficult task in a number of areas, such as the need to balance the right to health with other constitutional rights and social and economic interests.[3]

Another prominent concern was to ensure the separation of powers in the emergency management phase, in which the executive branch assumed a pervasive role, though often counterbalanced by a growing presence of scientific factors. Moreover, in decentralized states, the sanitary emergencies were often accompanied by centralization of functions and prerogatives, which sometimes led to conflicts of authority between different levels of government.[4]

Given the unprecedented measures adopted to address the multiple challenges of the pandemic, the entire structure of the form of government was affected, and the proactive or deficient response of central and local governments to the pandemic became a key factor in the next electoral consultations.[5] Notably, in certain cases the pandemic and the national recovery plans acted as a catalyst for change and development in the organization

[1] For an introduction see B. De Witte, *The European Union's Covid-19 Recovery Plan: The Legal Engineering Of An Economic Policy Shift*, in *Common market law review*, 3, 2021, pp. 635–681 and R. Porras, J. María, *EU Next Generation-Europe's recovery and resilience plan: a revolution in economic governance of EU?*, in *Diritto pubblico comparato ed europeo*, 4, 2021, pp. 821–852.

[2] See M. Graziadei, A. Somma, A. Vedaschi, *Diritto e pandemia: una riflessione comparatistica su rotture e* continuità, in *DPCE Online*, 1, 2023.

[3] See V. Piergigli, *Corti costituzionali e diritti ovvero l'onda lunga della risposta istituzionale all'emergenza sanitaria. Quali prospettive per il post-pandemia?*, in *DPCE Online*, 1, 2023, R. Balduzzi, *Il diritto alla salute durante e dopo la pandemia. "Milestones" per un confronto*, in *BioLaw Journal - Rivista di BioDiritto*, 4, 2021, pp. 39 – 55.

[4] This happened for instance in the Italian case but also in the Spanish. See on these aspects *ex multis* N.C. Steytler (ed.), *Comparative Federalism and Covid-19*, London, Taylor & Francis, 2022, L. Cuocolo (ed.), *I diritti costituzionali di fronte all'emergenza Covid-19: una prospettiva comparata*, in *Federalismi.it*, 2020, pp. 46 ff., R. Tarchi, *L'emergenza sanitaria da Covid-19: una prospettiva di diritto comparato. Riflessioni a margine di un seminario pisano*, in *Rivista del Gruppo di Pisa*, 1, 2020, M.C. Pérez Sánchez, *Derecho de Excepción, Constitución y Covid 19. Luces y Sombras Del Estado de Alarma En El Contexto Actual*, in *Política y sociedad*, 2, 2022.

[5] See E. Grosso, *Quello che resta. La forma di governo dopo l'emergenza: post hoc ergo propter hoc?*, in *DPCE Online*, S.l., 2023, pp. 2037-6677.

of health services and health systems in general, including the role of the private sector and the views on the right to health in different legal systems of the EU.[6]

All EU countries had to activate urgent public health measures and reorganize their national health services to contain the spread of covid-19. The EU also favoured Member States' initiatives on national health systems under the provisions established within the Recovery and Resilience Facility by Article 3(e) of EU Regulation 2021/241.[7] Yet not all public responses to the pandemic had the same impact on health systems and public health services in the European recovery plans.

A first type of response was that of those systems that opted for some degree of restructuring of their health systems in the aftermath of the pandemic (e.g., Italy and, to some extent, France). On the other hand, a less reformist group preferred to opt for a simple strengthening of the health system, without making deep changes in its main features (e.g., Germany).[8]

In this context, the Irish system was no exception to the dramatic consequences of the pandemic. Beyond the tragic loss of life, the COVID-19 emergency severely impacted the Irish economy and society, with infection peaking in 2021.[9] This required an effort of the state for around one billion euros of income support and subsidies in the worst parts of the pandemic[10].

The pandemic outbreak in Ireland struck a country still recovering from previous financial crises, and coincided with the final phase of Brexit, when the UK was leaving the EU's single market and customs in December 2020. Ireland was undoubtedly one of the countries most affected by Brexit, given its close trade ties with the UK.

Irish hospitals and intensive care units were under pressure, although not at the level of other European countries.[11] From the early stages of the pandemic, the government

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[6] R. Balduzzi, *Il diritto alla salute durante e dopo la pandemia*, cit., pp. 39 – 55.

[7] Regulation (EU) 2021/241 of the European Parliament and of the Council of 12 February 2021 establishing the Recovery and Resilience Facility. *Verbatim*: "The scope of application of the Facility shall refer to policy areas of European relevance structured in six pillars: (…) (e) health, and economic, social and institutional resilience, with the aim of, inter alia, increasing crisis preparedness and crisis response capacity". On this aspect see D. Bokhorst, F. Corti, *Governing Europe's Recovery and Resilience Facility: Between Discipline and Discretion*, in *Government and opposition*, pp. 1–17.

[8] See R. Balduzzi, *Diritto alla salute e sistemi sanitari alla prova della pandemia. Le "lezioni" di alcuni Piani nazionali di ripresa e resilienza*, in *DPCE Online*, 1, 2023, pp. 417 ff.

[9] COVID-19 emergency in Ireland led to a total number of confirmed cases (PCR) of 1,716,606 (up to 15 August 2023) and total deaths amounting to 9,148 as at the same date. See https://covid19ireland-geohive.hub.arcgis.com/, data based on official figures provided by the Health Protection Surveillance Centre (HPSC) and the Health Service Executive (HSE).

[10] According to the Irish Recovery plan, "In 2020, the Irish Government provided nearly €16.8 billion in direct expenditure interventions in response to the impacts of the pandemic, through supports such as the Pandemic Unemployment Payment, the Employment Wage Subsidy Scheme and the Temporary Wage Subsidy Scheme, and the COVID Restrictions Support Scheme (…) In Budget 2021 provision for a further €12 billion in expenditure was made in respect of COVID-19".

[11] Particularly Spain and Italy where the hospitals sufferance was overwhelming in many stages of the pandemic. See J. Mercille, *Ireland's takeover of private hospitals during the COVID-19 pandemic*, in *Health Economics, Policy and Law*, 17, 2022, pp. 232-237.

entered into agreements with private clinics in order to cope with the high demand for hospitalization.[12] In a system already characterized by a strong presence of the private sector in healthcare, this contributed to making the interactions between public and private actors more pervasive. But the Irish case is particularly interesting from a comparative perspective because long before the pandemic, Ireland began a profound debate on global health reform that led to the adoption of the 2017 *Sláintecare* Agenda, a long-term plan designed to revolutionize Irish healthcare.

Moreover, despite a substantial per capita health spending, Ireland found itself placed at the 80th position in the 2021 CEO World rankings of health systems, which takes into account factors including quality of healthcare professionals, facilities and accessibility to healthcare and medicines. This brought Prof. Martin Curly, an influential Irish expert, to argue in a recent article in the Irish Times that "of all the global healthcare systems Ireland's health system is perhaps the canary in the coal mine. Despite the recognition that we have excellent and committed clinicians and that, once you get into the system, care is good, we have a major problem. By a broad spectrum of measures Ireland's health system is one of the lowest performing in the northern hemisphere".[13]

In light of the above, this paper will try to situate the Irish case within the context of European recovery plans, in an attempt to understand how the COVID19 crisis impacted the organization of the Irish Healthcare System (hereafter also referred to as "IHCS") and how the Irish Recovery and Resilience Plan chose to intervene in health services in Ireland in light of previous general plans to reform the system. By analysing official documents issued by the Irish authorities and the EU institutions, as well as by reviewing relevant academic literature, the paper also aims to examine which of the general categories of responses outlined above the Irish case might fall into.

In this attempt, the second section presents the Irish constitutional context and the main features of the IHCS. The third section analyses the historical critical elements of the Irish healthcare system and the debate on its reform since the financial crisis of 2008. The *Sláintecare* plan is also examined in this section.

The next section seeks to understand how the pandemic shaped the context described in the previous sections and presents the main features of the Irish National Recovery and Resilience Plan. The fifth section focuses on the healthcare provisions in the Irish plan, while the sixth section briefly compares key aspects of the Irish policy with other European recovery plans. Finally, the last section of the paper discusses the main findings of the study.

[12] See S. Burke, S. Barry, Et. Al., *Slaintecare-a ten-year plan to achieve universal healthcare in Ireland*, in *Health Policy*, 122, 2018, 1278-1282.

[13] M. Curley, *Ireland's health system is one of the lowest performing in the northern hemisphere*, in *The Irish Times*, Wed Jun 21, 2023.

2. Background: Irish constitutional context and healthcare system before the outbreak of COVID-19

The Irish Constitution of 1937 is the only inter-war constitution still in force in Europe.[14] The Constitution combines elements of liberal democratic doctrines with the influence of the Commonwealth constitutionalism[15] and a wide cultural influence of Catholicism.[16] In the context of this study, it should first be noted that the Irish Constitution belongs to the group of constitutions without explicit references to the right to health. In fact, it does not recognize any specific obligation on the part of the State to guarantee the health of its citizens. The only reference to health is contained in Article 45, which envisages that the State shall ensure that the health of workers is not abused in work activities.[17] The provision is included in the section dealing with the "Directive Principles of Social Policy", which are intended as policy provisions addressed to the Irish National Parliament (*Oireachtas*).[18]
The absence of references to health in the Irish Constitution though is not surprising given the cultural climate in which the 1937 Constitution was adopted[19] but also in view of the global situation regarding the constitutional protection of health.[20] However, it is worth noting that in the years before the pandemic and particularly after the outbreak of COVID19, a certain debate arose among scholars in favour of the inclusion of a constitutional amendment to protect the health of the people.[21]

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[14] D.K. Coffey, *Drafting the Irish Constitution, 1935–1937 Transnational Influences in Interwar Europe*, Cham, 2018, 281.

[15] Especially with regards to the parliamentary institutions.

[16] This may be appreciated in the Preamble which reads "In the Name of the Most Holy Trinity, from Whom is all authority and to Whom, as our final end, all actions both of men and States must be referred, We, the people of Éire, Humbly acknowledging all our obligations to our Divine Lord, Jesus Christ, Who sustained our fathers through centuries of trial, Gratefully remembering their heroic and unremitting struggle to regain the rightful independence of our Nation, And seeking to promote the common good, with due observance of Prudence, Justice and Charity, so that the dignity and freedom of the individual may be assured, true social order attained, the unity of our country restored, and concord established with other nations, Do hereby adopt, enact, and give to ourselves this Constitution".

[17] *Verbatim*: "The State shall endeavour to ensure that the strength and health of workers, men and women, and the tender age of children shall not be abused and that citizens shall not be forced by economic necessity to enter avocations unsuited to their sex, age or strength». See J.M. Kelly (ed.), *The Irish Constitution*, Tottel, Dublin, 2006 and O. Doyle, *The Constitution of Ireland: a Contextual Analysis*, Oxford, 2018, pp. 1-3 who noted among the distinctiveness of Irish Constitution the «emphasis on the national distinctiveness of the new State and its reliance on the rich intellectual heritage of Roma Catholic social teaching".

[18] According to D.K. Coffey, cit., 241, the provision was influenced by the papal encyclical written in 1931 "*Quadragesimo Anno*" but also by Section V of the Constitution of German Reich of the 1919.

[19] See P. Biscaretti di Ruffia, *La costituzione dell'Irlanda (Eire)*, Florence, 1946, D.K. Coffey, cit., pp. 281 ff. and O. Doyle, cit., pp. 22 ff.

[20] According to a recent survey, only 14% of the constitutions of 191 UN countries examined between 2007 and 2011 included references to the right to public health. Only 9% of UN countries protect the right to free medical care, while more constitutions include medical care (38%) and health in general (36%). See J. Heymann, A. Cassola, A. Raub, L. Mishra, *Constitutional Rights to health, public health and medical care: the status of health protections in 191 countries*, in *Global Public Health*, 6, 2013, pp. 639 ff.

[21] See O. Bartlett, *Does Ireland need a constitutional right to health after the COVID-19 pandemic?*, in *Northern Ireland legal quarterly*, 2, 2022, pp. 365-379.

In this constitutional context, the Irish healthcare system has maintained elements in common with other developed European democracies, combined with certain peculiarities. Despite the undeniable initial influence of the United Kingdom, to which Ireland belonged until 1921, the IHCS model marked from the outset a certain distance from its neighbour, fostered by the pervasive influence of Catholicism in the entire constitutional system.[22]
Initially, the independent EIRE did not prioritize healthcare financially, relying instead on local government systems until 1970, although it did achieve some notable successes in efforts to eradicate tuberculosis in the 1940s. Another early milestone was the establishment of the Ministry of Health in 1947.[23]
Actually, the situation has proved to be quite different from the United Kingdom: the 1942 Beveridge report on social insurance[24] recommended a comprehensive system of social insurance and a National Health Service that would offer free healthcare to all citizens without financial barriers. Although the influence of the Beveridge Report can also be traced in Ireland, a similar proposal for a comprehensive healthcare system in the Irish Republic faced strong opposition from the medical profession and the Department of Finance. One of the most common objections was that the idea of universal social insurance, seen as a comprehensive welfare policy, was essentially not affordable for Ireland.[25].
Instead, the gradual evolution of healthcare and social policy in Ireland resulted in a "two-tier health service".[26] This led to a complex system of subsidized services, a combination of state and private health insurance plans and payments required for most healthcare services.[27] Ireland's system of public hospitals, most of which are university affiliated, is supported by private clinics and primary care physicians with a thorough and competitive medical education.[28]
Currently, the responsibility for policy guidance and administration of the IHCS falls under competence of the Department of Health, as well as the allocation of funds. The Health Service Executive (HSE), a governmental body overseen by the Department of Health, is also tasked with the management of publicly funded healthcare and social services.

[22] See R. Barrington, *Health, Medicine and Politics in Ireland 1900–1970*, in *Dublin: Institute of Public Administration*, 1987. As other scholars have noted, given the weakness of the post-independence government and the scarcity of resources, "The Catholic Church filled most of the gaps in social provision, including health, education, and maintenance of the poor (Ireland was roughly 95 percent Catholic at the time)". See P.H. Heavy, cit., p. 4.

[23] B. Harvey, *Evolution of health services and health policy in Ireland*, Dublin, Combat Poverty Agency, 2007, pp. 4 ff.

[24] On this topic see D. Béland, et al., *Translating social policy ideas: The Beveridge report, transnational diffusion, and post- war welfare state development in Canada, Denmark, and France*, in *Social policy & administration*, 2, 2022, pp. 315–328.

[25] See B. Harvey, *Evolution of health services and health policy in* Ireland, cit., pp. 4-5.

[26] S. Connolly, M.A. Wren, *Universal health care in Ireland—what are the prospects for reform?*, in *Health Systems & Reform*, 5.2, 2019, pp. 94-99.

[27] B. Harvey, *Evolution of health services and health policy in* Ireland, cit., p. 5.

[28] P. Heavy, *The Irish Healthcare System: A Morality Tale*, in *Cambridge Quarterly of Healthcare Ethics*, 28, 2019, pp. 276–302.

Among the major healthcare reforms enacted recently was the Health Act of 2004, which established the Health Service Executive, active from 2005.[29] Overall, access to healthcare is based on a combination of public and private systems, although it can be affirmed that the IHCS is not characterized by universal access to hospital-based primary care.[30]

A major component (approximately 69%) of the IHCS functionality is taxpayer funded[31] whilst the remaining portion of resources is based on a combination of private medical insurance payments (approximately 13%)[32] and payments made by the recipient of health-care services ("out-of-pocket payments").[33]

Given the cost of the systems to the users, by the 1970 *Health Act*,[34] a form of assistance for a minority of low-income and elderly users was introduced with the "medical card". This latter instrument allows access to public healthcare without additional charges and with limited charges for drugs, as well as the GP visit card, which is granted to a minority of people based on age or low income. It allows them to avoid paying for general visits to Irish general practitioners (GP).[35] In this context, it is not surprising that private insurance coverage is widespread and growing steadily, reaching around 53% of the Irish resident population in 2021.[36] The private insurance system is characterized by the presence of a public Health Insurance Authority, established in 2001, which is responsible for regulating the market. Private insurance policies generally provide access to medical care in both private and public hospitals.

Consequently, a patient wishing to access the healthcare system may first consult a primary care physician (at his or her own expense or through private insurance), who may then refer the patient to other specialists. On the other hand, in case of urgency, patients can access the local hospital's emergency system. In most cases, however, they will have to pay (directly or through their insurance company), except in the case of medical card

[29] B. Harvey, *Evolution of health services and health policy in* Ireland, cit., pp. 5-6.

[30] See M.A. Wren, S. Connol, *A European late starter: lessons from the history of reform in Irish health care*, in *Health Economics, Policy and Law*, 14, 2019, pp. 355–373.

[31] Scholars argue that the tax-finance component decreased after the 2008 financial crisis. See M. Wren, S. Connolly, N. Cunningham, *An examination of the potential costs of Universal Health Insurance in Ireland'*, Dublin, 2015, available at https://www.esri.ie/publications/an-examination-of-the-potential-costs-of-universal-health-insurance-in-ireland.

[32] This also grants preferential access to healthcare as noted by M.A. Wren, S. Connol, *A European late starter.*, cit., p. 357.

[33] M.A. Wren, S. Connol, *A European late starter.*, cit., p. 357, reporting data from the Irish Central Statistics Office updated to 2016.

[34] For an introduction see B. Harvey, *Evolution of health services and health policy in Ireland*, Dublin, Combat Poverty Agency, 2007.

[35] In addition, the fees of the visits are determined directly by the practitioners at a market rate.

[36] See the Health Insurance Authority publication "A review of Private Health Insurance in Ireland 2021". It should also be recalled that Ireland stands as a highly favoured European destination for corporate tax optimization. In fact, a fundamental corporate tax rate of around 12.5% contributes to indicate the country as a European fiscal paradise. See R. Dacher, *Hamiltonian shifts in state aid and the coming breakdown of the internal market: can the European union survive its covid-19 response?* in *Cardozo Int'l & Comp. L. Rev.*, fall, 2021, 13.

holders.[37] Patients with private insurance have access to the private healthcare system, where services are provided at market prices and can generally benefit from faster treatment times even in public hospitals. The other patients (those without a medical card) enter the public health system, where the quality of service is generally lower and slower.[38] Nevertheless, even the beneficiaries of the medical card experience poor quality of services and must wait longer for many treatments.

In recent decades, the Irish "two-tier system" has been consolidated by a series of incentives for the development of public hospitals and characterized by increased recourse to private insurance, accompanied by rising premiums.[39] Overall, Ireland has been placed among the first positions in the European Union for private health insurance spending in the national healthcare system.[40]

This model has turned out to be different from the main European alternatives of the Bismark model, based on the "insurance principle", and the Beveridge model. In a nutshell, while in the Bismarck model, based on the paradigm of social health insurance (SHI), residents are obliged to take out health insurance provided by public or private insurers, Beveridge-oriented models are universalistic and tax-financed with health services usually provided at the expense of general taxation and the government (e.g. Italy, Spain, UK).[41] While the two systems have shown some convergence in recent decades,[42] it is worth noting that Ireland hardly falls within the boundaries of any single model. In fact, the IHCS is based on a strong interaction between private and public systems[43] and combines elements of both models, leading scholars to argue about the uniqueness of the Irish sys-

[37] Medical cards are the main tool of the IHCS to provide diffuse access to health services for low-income beneficiaries. According to data updated to 2017, medical cards were only available to about 35 percent of the Irish population: see the study of the Centre for Health Policy and Management, Trinity College Dublin, "*Pathways Indicators*" at www.tcd.ie/medicine/health_policy_management/research/current.

[38] See M.A. Wren, *Unhealthy State: Anatomy of a Sick Society*, Dublin, 2003, 140 ff. For a clear explanation of the two-tier system in Ireland and its average cost see the example provided by S. Thomas, cit., 292: *verbatim*: "The population can be divided into two categories, determined by the 1970 Health Act. In category 1 are people with medical cards granted through the General Medical Scheme (GMS), which are primarily allocated on the basis of low income, after a stringent means test (…) In category 2 are those without medical cards, estimated at 64 per cent of the population in 2016, who as a consequence must pay full market prices for GP access (…) For example, patients pay an average of €52.50 per GP visit and up to €144.00 per month for prescription drugs. While everyone is eligible for public hospital care, those in category 2 pay €100.00 per emergency-department visit (without a GP referral) and €80.00 per day (capped at ten days per year) for hospital treatment (i.e., €800.00 annually)".

[39] P. Heavy, cit., 5.

[40] Specifically at the Second position after Slovenia according to T. Thomas, cit., 295.

[41] On the advantages and limits of the models see D. Béland, et al., cit., 315–328.

[42] According to T. Hoctor, *Beveridge or Bismarck? Choosing the Nordic model in British healthcare policy 1997–c. 2*015, Routledge, 2021, this is due to the fact that «both systems confronted similar challenges: expanding demand for care; aging populations; rising health complaints associated with poor lifestyles».

[43] See P. Heavy, cit., 7, according to whom, «The private system relies on the public: medical school is highly subsidized by the government; initial training of doctors occurs largely in public hospitals; doctors in the private system usually hold simultaneous jobs in the public system».

tem.[44] In light of recent evolution however, it is worth noting that the interest of the Irish system lies in the fact that "it is one of the few high-income systems that has not achieved significant progress toward universal health care".[45]

3. The debate on the reform of the IHCS and the *Sláintecare*

Even before the pandemic crisis, some authors suggested the existence of deep-rooted traces of crisis in the IHCS due to *inter alia* the shortage of beds, physicians, the length of waiting lists, and poor-quality standards compared to other EU countries.[46]
Austerity measures in the wake of the 2008 financial crisis appear to have contributed to a reduction in IHCS personnel and funding.[47] The drop in public spending on health was also a consequence of high unit costs for health services and pharmaceuticals compared to other countries.[48] On the other hand, Ireland's health spending as a percentage of GDP in 2019 was estimated at around 6.7%, on top of an EU average of 10.9%.[49] However, it was in the early years after the 2008 financial crisis that the key moment of a broad debate on a global reform of national health service in Ireland can be fixed.[50] In March 2011, the new Irish government chaired by Enda Kenny of the Fine Gael as *Taoiseach* in coalition with the Labor party committed to reform the IHCS. The drive for the reform was fueled by widespread public dissatisfaction with austerity measures implemented after the financial crisis that hit the Irish economy hard between 2008 and 2014 and the debate on the poor performances of the healthcare services.
It is in this context that the coalition made up of *Fine Gael*, the centre-right party, and the Irish Labour Party with left-oriented positions advanced the concrete proposal of establishing a universal single-tier health service that would overcome the two-tier system

[44] P. Heavy, cit., 5-7, According to M.A. Wren, S. Connolly, cit., 356, this may be also due to the unique combination in the Irish case of «Catholicism and medical politics» to which it is possible to add the influence of the common law constitutionalism.

[45] See S. Thomas, S. Barry, B. Johnston, R. Siersbaek, S. Burke, *Embracing and Disentangling from Private Finance*: *The Irish System*, in B. Thomas (ed.), *Is Two-Tier Health CareHealthcare the Future?*, University of Ottawa Press, Ottawa, 2020, 292.

[46] M.A. Wren, *Unhealthy State: Anatomy of a Sick Society*, Dublin, New Island, 2003, 16 ff.

[47] It is worth to note that the major source of funding (i.e. general taxation) showed a constant contraction from 2004. Cf. S. Thomas, cit., 292.

[48] Id., 293 ff.

[49] Irish spending reaches 11.1% considering the GNI. Per capita health spending however was closer to the EU average. Cf. B. Turner, *Putting Ireland's health spending into perspective*, in *The Lancet*, 391, 2018, 833-834. See also the report Vv. Aa, *State of Health in the EU Ireland Country Health Profile 2021*, cit. and for the EU statistics https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statistics#:~:text=All%20of%20the%20remaining%2014,and%20Romania%20(%E2%82%AC713).

[50] On this debate see *inter alios* S.A. Burke, C. Normand, et al., *From universal health insurance to universal healthcare? The shifting health policy landscape in Ireland since the economic crisis*, in *Health Policy*, 3, 2016, pp. 235–240.

and prioritize access based on medical need.[51] The influence of the international context and cultural climate on this choice should also be emphasized. In 2005, Ireland and other member states of the World Health Organization (WHO) made a strong commitment to achieving Universal Health Coverage (UHC). This commitment was later reaffirmed by the United Nations (UN) and the WHO in 2012 and 2013.[52]

A first concrete step towards this reform was the adoption of a plan known as the White Paper on Universal Healthcare of 2014.[53] The White Paper showed the commitment of the plan to replace the two-tier system with a single-tier system supported by universal health insurance. This new system was to provide integrated, safe, timely, and efficient care closer to the patient's home, with a priority system based on the principles of equal access to care and medical need rather than the ability to pay. The proposal seemed to be reminiscent of a Bismarck type system with a multi-payer universal health insurance model. However, this model was intended to involve competition between private health insurers and government actors. Full implementation at this stage was scheduled for 2019, although it was soon clear that the prediction was unrealistic.[54]

Following the White Paper, the 2016 general election campaign saw a generally favorable trend towards universal healthcare, although in quite vague terms.[55] After the elections, in 2017 the healthcare reform report named *Sláintecare*[56] was released by a parliamentary committee representing various political parties.[57] This report marked a cross-party agreement on healthcare reform and outlined the first detailed ten-year plan to transform Ireland's healthcare system.[58] The main scope of the plan could be considered the establishment of universal healthcare, intended to be a system that guarantees "popular, promotive, preventative, primary, curative, rehabilitative and palliative health and social care services to the entire population of Ireland, ensuring timely access to quality, effective, integrated services on the basis of clinical need".[59] The plan was structured in five sections based on

[51] See S.A. Burke, C. Normand, et al., cit., pp. 235–240.

[52] See S. Barry, et al., *Sláintecare – A ten-year plan to achieve universal healthcare in Ireland*, cit., 1283 ff.

[53] Available at https://www.imo.ie/policy-international-affair/overview/White-paper-on-Universal-Health-Insurance.pdf.

[54] S. Barry, et al., *Sláintecare – A ten-year plan to achieve universal healthcare in Ireland*, in *Health Policy*, 122, 2018, pp. 1278–1282.

[55] After the general election of February 2016 to renew the *Dáil Éireann*, the Prime Minister Enda Kenny's Fine Gael party managed to maintain the largest number of seats although the coalition government consisting of Fine Gael and the Labour Party lost its outright majority in Parliament. Cf. M. Gallagher, M. Marsh (eds.), *The election in context, in How Ireland Voted 2016*, London: Palgrave, 2016.

[56] "Report of the Committee on the Future of Health, Sláintecare Report" available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf.

[57] The "Committee on the Future of Healthcare" was made up of members from all the political parties and held public hearings held different hearings and public consultations.

[58] See V. Byers, *Health Care for All in Ireland? The Consequences of Politics for Health Policy*, in *World Medical & Health Policy*, 1, 2017, pp. 138–151.

[59] See page 55 of the report and S. Barry, et al., *Sláintecare – A ten-year plan to achieve universal healthcare in Ireland*, cit., pp. 1280 ff.

the submissions received[60] and namely "Population Health Profile",[61] "Entitlements and Access to Healthcare",[62] "Integrated Care",[63] "Funding"[64] and "Implementation".[65]

The Committee also identified eight fundamental principles to guide its discussions and form the basis for its recommendations. These principles included "Engagement", requiring building public and political confidence in the plan to create a responsive public health system comparable to other European countries; "Nature of Integrated Care", ensuring that all care would prioritize patients' needs; "Timely Access", providing timely access to all health and social care based on medical necessity; "Free Care", offering care free of charge and based on patients' clinical needs rather than their ability to pay; "Cost-Effective Care", encouraging patients to access care at the most appropriate and cost-effective service level and fostering the role of prevention in public health policies; "Enabling Environment", according to which it should be ensured that the healthcare service workforce is suitable, well-resourced and duly supported; "Public Interest Spending", a guiding principle which recommends that public funds should be used solely for the public good and finally, the principle of "Accountability and Governance", according to which accountability, effective organizational alignment, and good governance should be at the core of the health system's organization.[66]

The pre-pandemic implementation of *Sláintecare* showed some delays in early development, with slow progress and missed deadlines.[67] A nuanced vision emerged from scholars' overall discussion of the plan. There was a positive view of the plan's commitment to

[60] See page 14 of the Report.

[61] In which it is highlighted the need to pursue public health policies prioritizing individuals' well-being and reduce health disparities.

[62] The section recommends establishing a clear entitlement to universal healthcare through legislation. This should be pursued through the issuance of a "*Carta Sláinte*" i.e. a health card which allows access to healthcare services, including public health, preventive and primary care. See S. Barry et al., *Sláintecare – A ten-year plan to achieve universal healthcare in Ireland*, cit., pp. 1280 ff.

[63] The section emphasizes the importance of integrated care, which aligns health services across the lifespan and empowers individuals to manage their health. The section illustrates the impact of the WHO health system building blocks. The vision underlying this section is that "A national health service for the 21st century needs to deliver the 'triple aim' of health systems by improving care, improving health, and reducing costs". See page 18 of the Report.

[64] The financing of the healthcare system should be carried out through a National Health Fund. The resources needed to finance this fund should come from general tax revenues, earmarked taxes, and levies. This solution is designed in view of the awareness that taxation and social health insurance "are superior forms of health system funding rather than relying on out-of-pocket payments or private health insurance". Notwithstanding, according to the report "while taxation is the main funding source for healthcare in Ireland it has not raised sufficient sustained funds to provide entitlements to care, free at the point of delivery". The intention of the authors of the report is that, over time, there will be a reduction in the reliance on private payment and thus an increase in the proportion of public funding.

[65] The section emphasizes the importance of effective policy implementation, moving from the case study of international and national experiences. It is underlined the importance of setting up a Programme Implementation Office to avoid that "this is not just another report on the health sector which is not implemented" was pointed out.

[66] See S. Thomas, B. Johnston, S. Barry, R. Siersbaek, S. Burke, *Sláintecare implementation status in 2020: Limited progress with entitlement expansion*, in *Health Policy*, 3, 2021, pp. 277-283.

[67] S. Barry et al., *Sláintecare – A ten-year plan to achieve universal healthcare in Ireland*, cit., pp. 1281 ff.

eliminating access charges for some health services, such as primary care, to ensuring that wait times meet international standards and that access should be timely, and to removing private care from public hospitals and the option of paying for faster access in order to overcome some of the key limitations of dual access to public care.[68] The shift towards clinical needs-based treatment was also positively assessed.[69]
However, certain limitations and shortcomings of the plan were pointed out. These included the costs associated with reimbursing certain prescriptions and drugs, and the focus on reducing or eliminating fees for certain types of care rather than providing comprehensive access to care.[70] This brought scholars to argue that the *Sláintecare* "whilst providing political consensus and a costed plan and strategy to achieve a single tier system in some instances falls short of the ideal of UHC, which all plans will do to some extent".[71]

4. Response to the pandemic and the Irish Recovery and Resilience Plan (IRRP)

The first COVID-19 infections in Ireland were confirmed in February 2020 and the first death occurred on March 11. Overall, by August 2021, approximately 350,000 individuals (around 7.1% of the population) had received a positive diagnosis of COVID-19 through laboratory testing.[72]
In mid-March 2020, Ireland began implementing containment measures. These included closing schools, restricting public gatherings, and even closing businesses. A nationwide lockdown, requiring people to stay within two kilometers of their homes, was then enacted in March 2020, while the restrictions began to ease during the summer of 2020. Then, a new wave hit Ireland in October 2020, accompanied by new restrictions, although these were less severe than before. However, the peak of the infection was in January 2021,

[68] See S. Thomas, B. Johnston, S. Barry, R. Siersbaek, S. Burke, cit., pp. 278-279 and L. Marron, S. Burke, P. Kavanagh, *Changes in the utilisation of acute hospital care in Ireland during the first wave of the COVID-19 pandemic in 2020*, in *HRB Open Research*, 4, 2022.

[69] See S. Barry et al., *Sláintecare – A ten-year plan to achieve universal healthcare in Ireland*, cit., pp. 1281 ff.

[70] Limited are also the provision on home help and home healthcare.

[71] S. Thomas, B. Johnston, S. Barry, R. Siersbaek, S. Burke, cit., p. 279.

[72] This proved to be slightly inferior to the EU average of 8.2% across the EU. See https://health.ec.europa.eu/system/files/2021-12/2021_chp_ir_english.pdf. Also, the mortality rate was about one-third less than the EU average. It is important to consider also the average age of the Irish population: 38.8 in 2022, while the EU average age was 44.4 and the Italian average age was 48 (Eurostat demography of Europe 2023 edition in https://ec.europa.eu/eurostat/cache/digpub/demography/). For a global introduction of the reaction to the pandemic see S. Burke, S. Thomas, R. Siersbaek, *Ireland's response to the coronavirus pandemic – the August update (2020)*, in *Cambridge Core blog - Respons to the pandemic*, 2020.

when Ireland had a record infection rate of 921 weekly cases per 100,000 people. This wave was brought under control by February 2021.[73]

The 1937 Constitution of the Republic of Ireland contained no specific provision to regulate public health emergencies. The only reference to extraordinary regimes can be found in Article 28.3.3 of the Constitution, which, however, refers only to conflicts of war, insurrection against the state and does not seem suitable for its extension to public health emergencies.[74] The Irish response to COVID-19 was therefore coordinated by the Office of the Prime Minister, together with the Department of Health and the HSE. However, in January 2020, a National Public Health Emergency Team was established, chaired by the Chief Medical Officer and other experts. This team worked in close collaboration with another central crisis management body, the HSE's National Crisis Management Team and Crisis Communications Group.[75] In addition, a cross-party Special Cabinet Committee on COVID-19, chaired by the Prime Minister, was established, involving officials from all departments and agencies to ensure a comprehensive and synergistic government response. In common with many other foreign governments, the Irish government also disseminated several roadmaps and guidelines outlining strategies for resilience and recovery from COVID19 to provide clarity for citizens, businesses and healthcare providers.[76] The role of the outgoing Leo Varadkar government in the management of the pandemic, in light of the political framework set by the February 2020 general election for the new *Dàil Éireann*, is an interesting aspect to be noted.[77]. Given that the results of the elections did not grant a clear majority to any of the major political parties of the country,[78] the task of the Irish President in the choice of the PM (the *Taoiseach*) of a new government proved to be problematic in view of the high fragmentation of the parliamentary assembly.[79] In view of these fraught negotiations to be held at an arduous time, the outgoing executive maintained a key role in the management of the crisis and current affairs. As a result of the measures taken by the Irish government, there is evidence of widespread use of the national contact tracing system, which had a high diffusion rate to about half of the Irish population.[80]

[73] See https://health.ec.europa.eu/system/files/2021-12/2021_chp_ir_english.pdf and A. Greene, Ireland's Response to the Covid-19 Pandemic, in *Verfassungsblog*, 11 April 2020.

[74] See A. Greene, cit., pp. 2, O. Doyle, cit., pp. 99 ff. and G. Sardi, *L'emergenza sanitaria da Covid-19 nella Repubblica d'Irlanda. Strumenti giuridici per contrastare la pandemia e conseguenze problematiche sulla protezione dei diritti fondamentali*, in *DPCE Online*, 2, 2020, pp. 1813 ff.

[75] The most relevant legal corpus enacted in this period were the Public Interest Act 2020 and the Emergency Measures in the Public interest (Covid-19) Act 2020.

[76] See https://health.ec.europa.eu/system/files/2021-12/2021_chp_ir_english.pdf.

[77] On this aspect see G. Sardi, cit., 1812.

[78] I.e., *Sinn Fèin*, first party in the 2020 elections, *Fianna Fàil* and *Fine Gael*.

[79] Pursuant to Article 13 of the Constitution, the President is competent to appoint the Prime Minister on the nomination of the *Dàil*, and also the ministers of the cabinet on the nomination of the Prime Minister. See O. Doyle, cit., p. 74.

[80] So called Ireland Covid Tracker. Cf. S. Burke, S. Thomas, R. Siersbaek, *Ireland's response to the coronavirus pandemic*, cit.

The Irish government also implemented various measures to enhance and expand the capacity of the healthcare workforce during the pandemic. The number of full-time employees within the HSE was raised from 119,000 to 130,000 between 2019 and 2021, and additional measures encompassed an increase in work hours for part-time personnel and the rehiring of retired physicians.[81] Still, the COVID19 vaccination plan also played a key role in reducing mortality and keeping the pandemic under control. The vaccination campaign was launched in December 2020, prioritizing vulnerable groups by using an age-based priority criterion. By August 2021, more than 6.8 million doses of vaccine were administered in Ireland, with nearly 70% of the total population having received two doses.[82]
In this context, the Irish government published the 2021 National Recovery and Resilience Plan (hereafter "IRRP") with a package of reforms worth around €1 billion until 2026.[83] The plan was submitted to the European Commission on May 29, 2021, and received a positive recommendation. Given *inter alia* the high level of public debt after the financial crisis, Irish authorities did not opt for the request of financial support in the form of loans.[84]
In nuce, the Irish recovery Strategy sought to facilitate a sustainable, equitable, environmentally responsible and technologically advanced recovery. This aligned with Ireland's comprehensive economic recovery approach, supported by a substantial €165 billion national development blueprint spanning from 2021 to 2030. In compliance with the conditions of the Recovery and Resilience Facility, the plan allocated at least 37% of expenditure to climate-related initiatives and 20% to digital investments and reforms. More specifically, 41.9% of resources were designated for environmental endeavors and 31.5% for technological actions.[85] Furthermore, the INRRP addressed the investment and reform challenges identified in the EU country-specific recommendations for Ireland and was consistent with national economic and investment strategies, in particular the Economic Recovery Plan.[86] Notably, the plan was also developed through a quite diffuse use of public consultation.[87] Globally, Ireland's RRF grants were relatively small (around 0.3% of its 2019 GDP) if compared to the EU average of 5.2% of GPD. The direct impact on Ireland's macroeconomic

[81] B. Kennelly, et al., *The COVID-19 pandemic in Ireland: An overview of the health service and economic policy response.*, in *Health Policy Technol.*, 4, 2020, pp. 419-429.

[82] https://health.ec.europa.eu/system/files/2021-12/2021_chp_ir_english.pdf.

[83] Ireland is set to receive approximately €915 million in grants from the Recovery and Resilience Facility. The plan is available at https://www.gov.ie/en/publication/d4939-national-recovery-and-resilience-plan-2021/.

[84] See A. Eustace, *National Recovery and Resilience Plan: Ireland*, in *Italian Labour Law e-Journal*, S.I. 1, Vol. 15, 2022, p. 2.

[85] See the European Parliament study "*Next Generation EU (NGEU) delivery – How are the Member States doing?*" available at https://www.europarl.europa.eu/RegData/etudes/BRIE/2021/698848/EPRS_BRI(2021)698848_EN.pdf.

[86] Https://health.ec.europa.eu/system/files/2021-12/2021_chp_ir_english.pdf.

[87] According to the Plan a particular channel of discussion was established with social partners and stakeholders such as trade unions and employer representatives. Labor policy seems to be the main area of interest of the consultation. See A. Eustace, cit., p. 18.

indicators was expected to be limited, as the EU Commission has estimated a 0.3-0.5% increase of Irish GDP by 2026.[88]

5. Healthcare and the IRRP

The health-related provisions of the plan were mainly under the IRRP Component no. 3, which provided for "Social and economic recovery and job creation". Among the most notable of these was Priority 3.9. entitled "Progressing the strategic Healthcare reform agenda set out under *Sláintecare*, by committing to the implementation of three initiatives which would improve access to care in the community and begin the process of removing private healthcare from public hospitals".

In the intention of the drafters, the IRRP would further strengthen the capacity of the health system to provide competent and effective health services. A notable element was the reference to achieving the health goal outlined in the European Pillar of Social Rights, which states that "everyone has the right to timely access to affordable, preventive and curative healthcare of good quality", thus recalling the general objectives of the *Sláintecare*.[89] According to the plan, the implementation of the eHealth initiative, coupled with investments in community eHealth solutions, e-pharmacies and integrated care, would play a pivotal role in achieving the objective, thus showing a particular commitment to integrating digital solutions into healthcare reforms.[90]

Advancing the strategic health reform agenda of the *Sláintecare* with a commitment to improving access to community care and gradually reducing the presence of private healthcare in public hospitals was another key focus of the plan. Among the main health measures envisaged under Priority Component 3 were three distinct actions. These included: (i) implementation of the *Sláintecare* consultant contract, (ii) execution of the 2019 GP agreement to bolster community care by means of the adapted Chronic Disease Management

[88] Indirect effects stem from EU economic enhancement and cross-border effects. See the European Parliament study "*Next Generation EU (NGEU) delivery – How are the Member States doing?*" In https://www.europarl.europa.eu/RegData/etudes/BRIE/2021/698848/EPRS_BRI(2021)698848_EN.pdf.

[89] European Commission, Secretariat-General, European pillar of social rights, Chapter III, Social protection and inclusion, point 16 "Health", Publications Office, 2017, https://data.europa.eu/doi/10.2792/95934. On these aspects see S. Garben, *The European pillar of social rights: An assessment of its meaning and significance*, in *Cambridge Yearbook of European Legal Studies*, 21, 2019, pp. 101-127.

[90] A further €75 million would be spent on eHealth, including the digitalization of hospital management information systems (see project 2.6, priority 2 of the Plan). Pursuant to these objectives, in 2023 the Irish Health Minister jointly with the Department of Health and the Health Service Executive (HSE) introduced an online tool that visually presents health data and provides for insights into the health service's performance. The Prototype Visualisation Platform for the Health System Performance Assessment (HSPA) was designed to support policymakers, healthcare providers, researchers, and patients in assessing and enhancing system accountability and efficiency on the path to the development of universal healthcare. The platform compiles data on life expectancy, disease outcomes, health risks like smoking and obesity, service access, quality, and efficiency. See A. Eustace, cit., pp. 4 ff.

program (CDM) and (iii) implementation of the Enhanced Community Care Program, particularly with the establishment of operational community healthcare networks (CNHs).[91] Specifically, the IRRP outlined a new contractual framework for consultant physicians that prevented them from practicing outside the public health system, with the apparent intention of investing in the quality of public health services relative to private healthcare. Another key step was the expansion of primary care services to address the underperformance and cost inefficiencies of the Irish healthcare system, which were partly due to the practice of consultants splitting their time between public healthcare and the more lucrative private sector. On the other hand, the €75 million allocation for "eHealth" initiatives was intended to increase the use of technology in prescribing and managing patients' medications, and to create the infrastructure to support a mobile clinical workforce of health professionals providing services in the community and at home.[92]

The EU country-specific recommendations referred to in the plan focus mainly on improving access to healthcare and increasing the cost-effectiveness of healthcare facilities. Indeed, in its July 2020 specific recommendations on Ireland, the Council highlighted the existence of macroeconomic imbalances, mainly related to high levels of public and private debt. The Council also noted that a first step in addressing these imbalances would be to manage the impact of the COVID-19 pandemic and promote economic recovery. Despite the ongoing efforts of the *Sláintecare* reform, the Council noted that, from a structural perspective, Ireland's health system continued to struggle with issues of efficiency, adaptability, resilience and accessibility.[93] In this regard, the provision of INRRP was expected to increase the availability of social and low-cost housing, along with efforts to improve the accessibility and durability of the healthcare service. Together, these elements were also seen as key factors in strengthening the health, social and economic resilience of the country.[94]

The overall design of the plan suggests that the Irish authorities intended to use the post-pandemic recovery and the Next Generation EU funding as an opportunity to advance the *Sláintecare* reform agenda. The consensus on universal healthcare in Ireland gained momentum from the public health emergency. On the other hand, it seems clear that any profound reform of the IHCS was still at a very early stage of development.

Nevertheless, certain changes had already been implemented in the immediate aftermath of the COVID19 outbreak. These include a general increase in health budgets, the introduction of Individual Health Identifiers (IHIs) and the expansion of hospital bed capacity,

[91] See page 29 of the INRRP.

[92] A. Eustace, cit., 4.

[93] See page 9 of the report "*Next Generation EU (NGEU) delivery – How are the Member States doing?*" in www.europarl.europa.eu/RegData/etudes/BRIE/2021/698848/EPRS_BRI(2021)698848_EN.pdf.

[94] See Council Implementing Decision on the approval of the assessment of the recovery and resilience plan for Ireland of 16.7.2021 (COM/2021/419 final) and A. Eustace, cit., 5.

all of which were enacted in response to the pandemic. In addition, funding for *Sláintecare* during the pandemic exceeded the previous years' allocations.[95]

As far as health personnel is concerned, it is worth noting that after the reduction of medical staff during the financial crisis of 2008, which reached 8.1% at its peak, the increase in personnel was particularly accelerated during the COVID-19 period. In less than two years, there was an additional increase of 8.9%, which corresponded to around 10,000 human resources.[96]

The primary role of *Sláintecare*, rather than the Irish Recovery Plan, for the future of Irish health policy also seemed to be confirmed by the approval of a new implementation plan, i.e., the 2021-2023 *Sláintecare* Strategic Implementation Strategy and Action Plan.[97] This strategy intended on focusing efforts mainly on two lines of initiatives and strategies. The first program entitled "Improving Safe, Timely Access to Care and Promoting Health & Wellbeing" should pursue the organization of preventive measures and the increase in the capacity to accomplish the *Sláintecare* objectives especially in terms of timing of healthcare. On the other hand, the second program, entitled "Addressing Health Inequalities", is focused on the establishment of a universal healthcare, providing for eleven associated projects.[98]

6. The Irish Recovery Plan *vis-à-vis* other European experiences.

The Irish plan seems to have been based on the idea that the Irish authorities did indeed manage the pandemic adequately and that their intention was to implement the reform program set out in *Slaintecare*, rather than to reorganize the health system from scratch.[99]

[95] S. Burke, et al., *Building health system resilience through policy development in response to COVID-19 in Ireland: From shock to reform*, in *The Lancet Regional Health–Europe*, 9, 2021.

[96] See F. Padraic, et al., *Implications for health system reform, workforce recovery and rebuilding in the context of the Great Recession and COVID-19: a case study of workforce trends in Ireland 2008–2021*, in *Human Resources for Health*, 20.1, 2022, pp. 1-11.

[97] The document was published on 11 May 2021 and is available at https://www.gov.ie/en/publication/6996b-slaintecare-implementation-strategy-and-action-plan-2021-2023/.

[98] Project 1 — Develop a Citizen Care Masterplan; Project 2 — Implement *Sláintecare* Healthy Communities Programme Project 3 — Develop Regional Health Areas Project 4 — Implement Obesity Policy and Action Plan 2016 — 2025.

[99] Actually, the supportive role of the Plan with respect to the implementation of the *Sláintecare* was underlined by the Council in the Council Implementing decision on the approval of the assessment of the recovery and resilience plan for Ireland of 2021, in which the European institution recommended that "The cost-effectiveness, accessibility, and resilience of the healthcare system are also expected to be addressed by the RRP. A reform measure should support the implementation of *Sláintecare*, a major and long-term domestic health reform initiative currently underway, which aims to achieve a modern universal single-tier healthcare system where everyone has equal access to services based on need, and not on ability to pay".

This can be better understood by comparing the Irish plan with other recovery plans in the European context.

A first element of discussion was the absence of healthcare as a pillar objective of the Irish Plan. In fact, the IRRP sets 3 main components. Component 1 is entitled "Advancing the Green Transition" and sought to strengthen investments aimed at facilitating Ireland's transition to sustainability. Component 2, "Accelerating and Expanding Digital Reforms and Transformation", placed digitization at the center of the political agenda and committed to modernizing digital public services and promoting digital awareness and skills. Finally, Component 3, "Social and Economic Recovery and Job Creation" was dedicated to mitigating the social and economic impact of the pandemic in Ireland, with the primary objectives of facilitating the reintegration of the workforce and equipping citizens to face future economic challenges. Conversely, "Healthcare Reform" appeared only as the last sub-objective (no 3.9 as above) of Component 3, indicating the intention of the Irish government to continue the strategic healthcare reform agenda set out under *Sláintecare*. This marked the distance of the Irish case from other European recovery plans where health reforms were a major and priority component of their plans. This was the case, among others, of Italy with Mission 6 of the PNRR, of Slovakia with Area 4 of its Recovery Plan, of Finland with Line 4 of its Recovery and Resilience Plan dedicated to health and social services, and of the Czech Republic, Romania and Greece. Indeed, the Italian Plan for Recovery and Resilience (PNRR), although moving from the idea of an overall assessment of the adequacy of Italy's response to the pandemic, as in the Irish case, provided for a series of objectives to restructure health services in light of certain aspects highlighted by the pandemic.[100] In a nutshell, Italy's strategy revolved around improving healthcare infrastructure at the regional level while harnessing the potential of digital health technologies.[101] A common focus was the issue of personnel and human resources for health services, which came to the fore in both the Italian and Irish cases, but also the strengthening of the healthcare system.[102] In addition, the Italian PNRR seemed to share with the Irish plan the intention to invest in e-health. However, although the digitization of health services seemed to be a major concern in the Irish plan, it only played a secondary role in the Italian plan.[103]

[100] Reference is made to, *inter alia*, significant territorial disparities in service delivery, particularly in terms of prevention and care in the territory, inadequate integration between hospital services, territorial services territorial services and social services and high wait times for the provision of certain services. See page 225 of the PNRR and G. Razzano, *La missione salute del PNRR. Le cure primarie, fra opportunità di una "transizione formativa" e unità di indirizzo politico e amministrativo*, in *Corti Supreme e Salute*, 2, 2022, pp. 1-36; B. Perego, *PNRR e Salute nella dinamica della forma di Stato*, in *BioLaw Journal*, 1, 2023, pp. 99-113.

[101] See R. Balduzzi, cit., *passim*, and D. Morana, T. Balduzzi, F. Morganti, *La salute "intelligente": eHealth, consenso informato e principio di non-discriminazione*, in *Federalismi.it*, 34, 2022, pp. 127-151

[102] Cf. R. Balduzzi, *Il diritto alla salute durante e dopo la pandemia. Milestones per un confronto,* cit. pp. 39-55.

[103] See Mission 6 "Health", component 1 of the Italian PNRR entitled "Neighborhood networks, facilities and telemedicine for community health care" and the Italian Ministerial Decree 77/2022. On this topic see R. Balduzzi, *Diritto alla salute*

However, e-health and digitalization may have also been valued in the French plan. Indeed, the *Plan pour la reprise et la résilience de la France* included health and economic, social and institutional resilience as pillars of the recovery strategy and foresaw massive investments in public health and the adoption of a national strategy for healthcare reforms.[104] The modernization of hospitals and residential facilities for the elderly and disabled was another key focus of the French plan, which did not appear to be developed to the same extent in the Irish recovery strategy. An interesting common element between the French plan and the Irish process of approving *Slaintecare* was the periodic consultation of stakeholders and, in some cases, the generality of citizens, on major decisions for national health policy. In fact, the French experience highlighted the role played in this context by the *Ségur de la santé*, a semi-permanent health policy roundtable. However, a similar consultation of national stakeholders and citizens seems to be lacking in the Italian context.[105]

On the other hand, as in the case of Italy, the French government approved structural measures and investments that were considered essential for a strong integration of all the different components of the healthcare systems to avoid future collapse and to ensure health service resilience. These included the *soins hospitaliers*, i.e., where the public hospitals would provide for short-and medium-stay admissions, the *soins de ville* which consisted in those healthcare services provided by healthcare professionals outside of hospitalization or placement in health and social services facilities, which were also indicated as *établissements médico-social*.[106]

While a similar effort appears to be absent in the Irish plan, the aim of achieving an integrated healthcare system by strengthening the link between public healthcare and public and private social and health institutions can be appreciated within the initiatives funded by the *Sláintecare* Integration Fund. According to a recent program report published on July 20, 2022, since 2019,[107] this program has allocated millions to support more than one hundred projects led by the Health Service Executive (HSE) and NGOs, primarily focused on the transition of healthcare services to the community, exemplifying best practices in the management of chronic diseases and care for the elderly. A key aim of the plan was also to empower individuals to take an active role in managing their own health and to

e sistemi sanitari alla prova della pandemia, cit., 420 and D. Morana, T. Balduzzi, F. Morganti, cit., pp. 127-151.

[104] Cf. https://minefi.hosting.augure.com/Augure_Minefi/r/ContenuEnLigne/Download?id=76326F03-443F-4B0E-9C33-BB5CA147E1F7&filename=PNRR%20- 20Synth%C3%A8se%20%28FR%29.pdf. See P. Bisciari, W. Gelade, W. Melyn, *Plans nationaux de relance et de résilience de la France et de ses principaux pays voisins*, in *Revue française d'économie*, 36.3, 2021, pp. 19-64 and A. Morelle, D. Tabuteau, *La santé publique*, Paris, 2021. For an introduction of the French system see A. Laude, B. Mathieu, D. Tabuteau, *Droit de la santé*, Paris, 2009.

[105] See R. Balduzzi, *Diritto alla salute e sistemi sanitari alla prova della pandemia*, cit., 421 ff.

[106] Id., pp. 421-422.

[107] The report is available at https://www.gov.ie/en/publication/025e7-slaintecare-integration-fund-end-of-programme-report-2022/.

encourage innovative approaches to healthcare. Although the report highlights the positive impact of these projects on the healthcare system, such as the reduction of hospital admissions and emergency room visits, it seems that the outcome of these initiatives will not be decisive in achieving health system resilience, given the limited resources used compared to the French experience.[108]

The German recovery plan[109] also appears to present similarities with the overall aims of the Irish recovery and resilience plan. In particular, the German plan shares the idea of an overall positive response to the pandemic by the German healthcare system. Therefore, other issues such as the ecological transition, including decarbonization, seem to be the focus of the plan. On the other hand, the idea of a deep reform of the German healthcare system seems to be missing from the DARP. Of course, this does not prevent the DARP from allocating resources to the strengthening of the healthcare system and, in particular, to the development of the capacity to resist and manage future health crises.[110] It is not surprising, therefore, that the German plan emphasized the digitization of health services (another feature in common with the Irish case) and investment in digital resources for hospitals and health facilities as key concerns.[111]

7. Concluding remarks

Signs of crisis in Ireland's health system predated the pandemic. These issues proved to be both cultural and functional, affecting the quality of health services and bringing out problems such as bed shortages, lack of doctors and long waiting lists. Notably, Ireland embarked on a path of comprehensive IHCS reform well before the pandemic. The pivotal moment for reform discussions came in the aftermath of the 2008 financial crisis, when public dissatisfaction grew due to austerity measures and cuts in staffing and funding. Ireland's commitment to universal health coverage (UHC) and the replacement of the two-tier system, which had ancient roots, emerged slowly but clearly from the early 2010s with the 2014 White Paper, which emphasized equal access based on medical need. The 2017 *Sláintecare* report condensed these trends into a ten-year plan to transform Ireland's

[108] On the *Sláintecare* Integration Fund see M. Farrell, *Leading an innovative approach to prevention, community care and integration of care in Ireland*, in *International Journal of Integrated Care (IJIC)*, 22, 2022.

[109] Known as DARP - *Deutscher Aufbau- und Resilienzplan*. See for a general introduction U. Villani Lubelli, *La pandemia del Covid-19 in Germania: le istituzioni sanitarie e politiche della Repubblica Federale alla prova dell'emergenza*, in *Res Publica: rivista di studi storico politici internazionali*, 1, 2021, pp. 195-205, L. Sandberg Päivi, M. Ruffert, *Next Generation EU and its constitutional ramifications: A critical assessment*, in *Common Market Law Review*, 59.2, 2022.

[110] Cf. J. Hacker, *National Recovery and Resilience Plan: Germany*, in *Italian labour law e-journal*, 1S, 15, 2022.

[111] See in particular component 5.1. of the DARP and R. Balduzzi, *Diritto alla salute*, cit., pp. 421-422 according to whom the choice made by DARP is clearly in the direction that the strengthening of the Public Health Service in a sustainable dimension should give clear priority to digital infrastructure.

healthcare system, emphasizing universal coverage and access based on clinical need with broad cross-party agreement.

Considering the ambitious policy program of *Sláintecare*, scholars welcomed certain elements of progress, but also recognized room for improvement in achieving a functioning single tier health system and overcoming challenges such as prescription costs and limited access to care. Nevertheless, the implementation of *Sláintecare* prior to the pandemic proved difficult, with slow progress and several missed deadlines, leaving an ideal of UHC in Ireland far from being realized at the outbreak of COVID19.

The Irish response to the emergency therefore took place within the traditional two-tier health system. As in many other countries, the executive acted as the protagonist in this phase, with extensive powers to deal with the emergency.[112] The government response was coordinated primarily by the Office of the Prime Minister, the Minister of Health, and the Ministry of Health, with the establishment of a National Public Health Emergency Team.[113] In response to the COVID-19 pandemic in Ireland, containment measures were implemented in 2020, including lockdowns and restrictions on public gatherings. While the country faced multiple waves of the virus, with the peak in January 2021, it has been noted that the main areas of Irish policy during the first phase of the pandemic were focused on the control of the contagion, resources for residential care, and testing and treatment of the disease[114], while afterwards, the efforts of the government were mainly focused on vaccination.

It is worth adding that in the Irish Republic, unlike other systems, no formal declaration of emergency was issued following the outbreak of Covid-19 to justify the exceptional provisions introduced and the corresponding "tensions" in the area of the "material constitution"[115], as well as on the grounds of guaranteeing human rights and the prerogatives of the *Oireachtas*.[116]

Overall, considering the capacity constraints of public hospitals before the pandemic,[117] the Irish health system was able to withstand the COVID19 outbreak, in particular showing results compatible with the average of EU countries, especially in acute care, despite

[112] Especially further to the amendments to the Health Act 1947 allowing the government to adopt special provisions deemed to prevent the spread of the infectious disease, including *inter alia* limitations to travel restrictions. See G. Sardi, cit., p. 1817 and A. Greene, cit., *passim*.

[113] See on the provisions of Public Interest Act 2020 related to the Minister for Health the remarks of A. Green, cit., pp. 3 ff.

[114] See N. O'leary, L. Kingston, et. al., *COVID-19 healthcare policies in Ireland: A rapid review of the initial pandemic response*, in *Scand J Public Health*, 49, 2021, pp. 713-720.

[115] To borrow a widespread expression of C. Mortati, *La costituzione in senso materiale*, Milano, Giuffrè, 1998. For a general introduction see J. Colón-Ríos, *'The Material Constitution', Constituent Power and the Law*, Oxford, Oxford Academic, 2020.

[116] A. Green, cit., pp. 3 ff.

[117] C. Keegan, A. Brick, et. al., *How many beds? Capacity implications of hospital care demand projections in the Irish hospital system*, 2015-2030, in *Int J Health Plann Mgmt*, 2019.

critical care demand and severe capacity constraints.[118] The use of innovative solutions, especially in the area of tracking contagions, should also be highlighted.
In this context, the Irish National Recovery and Resilience Plan of 2021 (IRRP) chose to prioritize digital investment, economic recovery and climate action, rather than making a significant shift in Irish health policy. The IRRP enhanced healthcare in its "Social and Economic Recovery and Job Creation Component", but despite the pandemic-related investments in the budget and staff increases, the main health policy objectives were related to the advancement in the implementation of the *Sláintecare* reform agenda as well as investment in the digitalization of healthcare services. According to the plan, this would also have involved improving access to community care and reducing the provision of private care in public hospitals, in line with EU recommendations to increase the accessibility and cost-effectiveness of healthcare.
In conclusion, the Irish plan appears to have had features in common with both of the groups outlined in the introduction when compared with other public responses to the pandemic and European recovery plans. On the one hand, it seems that it was closer to the category of countries that decided to move towards a simple strengthening of the health system, rather than opting for a profound reorganization of the health system.[119] Indeed, the analysis carried out in the previous sections showed that in the overall objectives and priorities of the Irish plan, the provisions devoted to healthcare played a secondary role, especially when compared with the priorities envisaged in other plans (e.g. Italy). However, while in other cases, such as in Germany, this was mainly the result of the idea of an overall positive response of the health system to the pandemic and the need to be prepared for possible future pandemics, the Irish case showed some noteworthy peculiarities. The pandemic and the recovery plan in Ireland were in fact situated in a deep-rooted and ongoing process of rethinking the Irish health service towards a single tier system grounded on universal access based on clinical need. It is not surprising, therefore, that the IRRP was essentially seen as an opportunity to speed up the implementation of the ongoing *Slaintecare* reform, which was already stagnating before the pandemic, rather than a chance to redesign a new strategy for health policy. However, in this "conservative reformism" that characterized the Irish Plan and the additional 2021-2023 *Sláintecare* Strategic Implementation Strategy and Action Plan, early commentators saw an opportunity to reinvigorate the implementation of the *Sláintecare* agenda. Thus, it has been noted that "Ireland's investment in its health care system has produced the potential to restore and rejuvenate the *Sláintecare* reform programme, all in the middle of a global pandemic.

[118] B. Walsh, C. Keegan, A. Brick, S. Lyons, *How is Ireland's healthcare system coping with coronavirus?*, in https://www.economicsobservatory.com/how-irelands-healthcare-system-coping-coronavirus.

[119] R. Balduzzi, *Diritto alla salute e sistemi sanitari alla prova della pandemia*, pp. 417 ff.

Realising, harnessing and maintaining any positive change achieved to date is a further challenge for the Irish health system".[120]

In any case, the multiplication of different political strategies and action plans[121] combined with the IRRP would seem to pose risks or at least complicate the effective implementation of a comprehensive reform if not accompanied by adequate means of integration and coordination. There seems to be no trace of such means in the IRRP, just as there was no mention of the need to adopt a comprehensive and multidisciplinary approach to healthcare that would facilitate the process, such as the "One Health" approach, in the part of the Recovery Plan related to healthcare.[122]

However, before the critical juncture that Ireland faced in the early 2010s of whether to continue on its existing path or to make progress toward achieving universal coverage, recent developments have seemed to signal that the Irish health system is leaning toward this latter option, with the IRRP acting as a catalyst for the changes underway, albeit still in their early stages.[123]

[120] S. Burke, et al., *Building health system resilience through policy development in response to COVID-19 in Ireland: From shock to reform*, cit.

[121] Considering the last years and beside the plans already recalled, mention is made *inter alia* to the National Action Plan in Response to COVID-19, the Resilience and Recovery 2020-2021: Plan for Living with COVID-19 and the Healthy Ireland Strategic Action Plan 2021–2025.

[122] R. Balduzzi, *Diritto alla salute e sistemi sanitari alla prova della pandemia*, pp. 417 ff. Such an approach, however, has been recently considered in other sectorial national plans for health by Irish authorities, such as Ireland's Second One Health National Action Plan on Antimicrobial Resistance 2021-2025. For a general introduction of the One health approach see the special issue no. 3/2022 of *Corti Supreme e Salute* and B.R. Evans, F.A. Leighton, *A history of One Health*, in *Rev Sci Tech*., 2, 2014, 413 – 420.

[123] In this sense see the remarks of S. Burke, et al., *Building health system resilience through policy development in response to COVID-19 in Ireland: From shock to reform*, cit. according to whom "COVID-19 provides governments with a unique opportunity to build health system resilience. Low interest rates in Europe and the priority status of the health sector create a window of opportunity. Advancing reform in a shock is a sign of transformative health system resilience. Furthermore, enhancing the functioning of a health system and delivering universal access itself builds health system resilience. Further research is needed to understand the optimal strategies to take forward reform and resilience building in shocks in different countries".