



Barriers and Facilitators to National UHC Health Reform Implementation: A Qualitative Case Study of Sláintecare in Ireland

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Abstract

Background: While universal health coverage (UHC) is at the fore of contemporary international health system discourses, its introduction often necessitates far-reaching reforms and countries face a number of challenges to implementation. Ireland is one country that has introduced a national health reform policy, Sláintecare, which aims to achieve UHC. The purpose of this paper is to examine the case study of Ireland, utilising findings from our realist review on international reform implementation as a conceptual framework, thus deepening our understanding of the barriers and facilitators to implementation.

Methods: This paper examines the case study of health reform implementation in Ireland, drawing on qualitative data collected through semi-structured elite interviews with 16 senior Irish health system leaders, healthcare workers, political advisors, union representatives, and private sector stakeholders. Following ethical approval, interviews took place from July 2024–April 2025. With our realist review providing an analytic framework, NVivo 12 qualitative analysis software was used to conduct thematic analysis, deductively in the first instance using a predetermined coding tree and then inductively based on emerging themes.

Results: Participants highlighted a number of factors that acted as barriers or facilitators to implementation. Barriers included a lack of capacity and infrastructure, challenges around financing and a lack of clarity around universalism and universal healthcare. Additional barriers included a lack of public engagement with Sláintecare as well as challenges around priority setting. Meanwhile, political commitment, as well as a programmatic approach, facilitated reform implementation, while the COVID-19 pandemic both stymied and enabled reforms.

Conclusion: Through using this framework to test the Irish experience, the authors provide further evidence regarding the barriers and facilitators to implementation of UHC, adding to the international discourse and work being done on these important reforms. These learnings have implications for workforce capacity development, digital health infrastructure and health financing, amongst other policies.

Keywords: Universal Health Coverage, UHC, Health Reform, Health Policy, Ireland, Sláintecare

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Introduction

Universal health coverage (UHC) is at the fore of contemporary international health system discourses, with 193 countries committed to its introduction by 2030 under the Sustainable Development Goals. However, the introduction of UHC often necessitates far-reaching health system reforms.¹ This, coupled with the challenges that many countries face in relation to health financing, as well as distinct political, social and cultural contexts, means there can be a number of barriers to implementation.²

However, countries around the globe have found mechanisms that facilitate the reform process. Findings from an international realist review suggest that for health reforms to be facilitated, there must be cohesion across health system sectors and stakeholders, as well as the functions of financing, governance, and service delivery.³ This includes political

support, as well as communication between stakeholders and the development of a strong primary care sector. Conversely, the review also found that fragmentation across these systems and functions pose significant barriers to reform.

Ireland is one such country that has introduced a national health reform policy, Sláintecare, which aims to achieve UHC. Eight years into its implementation phase, the policy has made some progress towards implementation but has also faced a number of challenges, not least of which included the global COVID-19 pandemic.

This article examines the Irish experience of health reform implementation through the prism of international experiences of effective implementation mechanisms. In particular, this article focuses on high-level policy developments since the introduction of Sláintecare. In doing so, the authors provide further evidence regarding the barriers that impede and the

Key Messages

Implications for policy makers

- Key to the implementation of health reforms in Ireland has been the unique all-party political consensus and support for the reforms.
- While crises such as the COVID-19 pandemic can impede reforms, they can also be harnessed and utilised as cataclysms for implementation.
- Policy-makers, politicians and civil servants must collaborate to secure adequate funding for both ongoing maintenance of health services and also for reforms throughout their implementation phase.
- Consensus around the definition of universalism, and the optimal mechanisms for implementing universal health coverage (UHC), can facilitate reform implementation.
- Strengthening capacity and infrastructure, particularly within primary healthcare, can greatly facilitate reforms and the introduction of UHC.

Implications for the public

Universal health coverage (UHC) can provide greater access to healthcare for you and your loved ones, reducing financial barriers and enabling more people to receive healthcare when they are sick. Furthermore, strengthening our primary healthcare system enables you to attend the general practitioner (GP) or other healthcare providers in your local community, instead of waiting long hours in hospital or travelling long distances. This also frees up our hospitals so that when you do have an emergency or face a health crisis, you can receive timely and quality care in hospital. Ireland's health system is currently being reformed so that these two changes – bringing in free, accessible care and strengthening our primary care system – can take place. This paper looks at the issues that have acted as barriers and facilitators to bringing in reforms, and in doing so will hopefully help to bring about reforms and improve healthcare for everyone.

facilitators that support the implementation of UHC, adding to the international discourses and work being done on these important reforms around the world.

The Irish Health System – a Brief Overview

The Irish health system has been historically underfunded, with inconsistent and inequitable access to services a persistent feature of healthcare provision.⁴ This consistent underfunding has led to chronic public sector capacity and infrastructural issues, along with very long waiting lists, exacerbated during the austerity years following the financial crisis of 2008 and by subsequent shocks.^{5,6} In response, nearly half the population, 47%, or 2.52 million people, hold private health insurance.⁷

The Irish health system's primary source of revenue is general taxation, although this does not confer universal access.⁸ Coverage and access to primary care has remained problematic, as Ireland remains the only Western European country to charge market prices for primary care access to the majority of residents.⁹ A number of cohorts receive some financial protection, based on income, age, and condition. As of November 2024, over 1.57 million people held medical cards, which provide universal access to care, while just over 702 000 additional individuals held general practitioner (GP) Cards, entitling them to free care from their GP.¹⁰

Sláintecare: Towards Universalism and Integration

The Irish health reform programme, Sláintecare, was introduced to address many of these issues around access, eligibility and coverage. In May 2017, an Irish cross-party parliamentary committee published the Houses of the Oireachtas Committee on the Future of Healthcare “Sláintecare” report. The report, known as “Sláintecare,” outlined a high-level policy roadmap for delivering whole system reform and universal healthcare, phased over a ten-year period and costed.¹¹ Sláintecare is Ireland's first attempt to provide systemic, large-scale reform with cross-party political consensus.¹¹

Two key elements of the reform include the need to

move towards universal healthcare and a reorientation of the current, hospital-centric model towards integrated primary and community care.^{11,12} Within this, Sláintecare has five interrelated components: entitlements and access to healthcare, population health, integrated care, funding, and implementation.¹¹

In recent years, the Irish government has introduced a number of policies that were either specified within Sláintecare or aligned with its overall aims.⁶ For example, in September 2022, in-patient hospital fees for people under the age of 15 were abolished. In 2023, free GP care was extended to all children aged 6 and 7 and further extended to people with a median household income of €46 000 or less. Furthermore, the acute public in-patient charge of €80 per day was removed, up to a maximum of €800 in a year, for people over the age of 15 accessing care as a public patient in public hospitals.⁶

The reform programme also included a reorganisation of governance structures within the Health Service Executive (HSE), the national public body charged with delivering health and social care. This shift has devolved many management responsibilities from national HSE offices to six regional offices across the country. These reforms were included in Sláintecare in the hope of delivering targeted, population-based and better integrated care.¹³ However, the significant work that has been done in relation to the ongoing process of decentralisation, as well as the complex and evolving relationship between the public and private systems, are not presented below, as these issues are currently being reviewed by our research team and are outside the scope of this article.

Methods

Utilising the findings from our realist review on international UHC reform implementation as a conceptual framework, this paper examines the case study of health reform implementation in Ireland, drawing on qualitative data.³ Specifically, our international review provided themes around the barriers and facilitators to reform that enabled us to test the Irish experience. Situated within this framework, our research question for this case study was: What are the

barriers and facilitators that have influenced the Sláintecare health reform in Ireland 2017-2025, according to high-level stakeholders mandated to implement reforms, and how do these factors compare to other international experiences of UHC reform implementation?

The study employed elite interviewing to examine health reform implementation from the perspective of actors directly involved in its development and implementation,^{14,15} although three participants were recruited via snowball sampling.^{16,17} Elite interviewing is a qualitative approach often utilised to examine policy-making or institutional decision-making within business or society, from the perspectives of those with direct knowledge of or influence over the process under investigation.^{14,15}

The qualitative data was collected through semi-structured interviews with 16 senior Irish health system leaders, analysts, healthcare workers, policy-makers, union representatives, and stakeholders from the private sector as part of RESTORE, a five-year research project examining health system resilience and reform, funded through the Health Research Board’s Research Leader Award (See Table 1 for participant characteristics). All participants held responsibility for implementing some aspect of Sláintecare or directly influenced its development, and thus were ideally situated to answer our research question. The concept of information power, which posits that a low number of participants can be included when the participants hold a high level of information relevant to the research topic, was utilised to determine sample size.^{18,19} Results from our realist review shaped our initial interview guide. Interviews took place over a 10-month period, from July 2024-April 2025, either in-person or online, depending on each participant’s preference, and lasted for 60-90 minutes. Interviews were recorded, following written and verbal consent from participants, and transcribed electronically. The transcripts, which were password protected, were cleaned, with names anonymised and identifiable details redacted. Interviews were then listened to again by the first author, *in toto*, so as to further familiarise herself with the data, and correct any discrepancies between the transcript and the recording.

Data analysis was led by the first author. NVivo 12 qualitative analysis software was utilised to conduct thematic analysis, deductively in the first instance using a predetermined coding tree (informed by our realist review) and then inductively based on emerging themes.³ Specifically, the context-mechanism-outcome configurations (CMOCs) from the

realist review centred around strong governance, financing UHC, health system infrastructures, political commitment, and communication (See Supplementary file 1 for more details on the CMOCs). These categories informed and shaped our initial deductive codes. Inductive coding began as different participants highlighted similar issues, such as the COVID-19 pandemic and definitions of UHC, but ones that fell outside the CMOC-informed deductive codes.

Both deductive and inductive themes were then compared and discussed with the project’s principal investigator (ST) and the wider research team. Through these discussions, the authors were able to develop the inductive themes, clarifying and refining them. Initial findings were then presented to policy-makers and healthcare workers at a research conference in November 2024. Feedback from this informed the further development of inductive themes and the robustness of the findings. Revised findings were then triangulated, to determine credibility, using results from other ongoing workstreams within the wider RESTORE project. Within this paper, the results are presented through direct quotes from the participants, in order to facilitate transparency,²⁰ with quotes included based on their representativeness and succinctness, while also capturing the nuances of opinion.

Reflexivity is an integral component of qualitative research, and the researchers were able to draw on their lived experiences as a resource while taking measures to ensure credibility and replicability.²¹ The third author (and principal investigator for this research) led the technical team to support the development of the cross-party Committee on the Future of Healthcare Sláintecare report, published in 2017. Furthermore, the third and first author, who both conducted the interviews, believe that the international commitment to UHC, under the Sustainable Development Goals, should be implemented in Ireland and globally. During the elite interviews, both authors were able to draw on these experiences and values to build trust and rapport with participants,¹⁴ ask relevant questions that encouraged rich data and situate participants’ involvement in Sláintecare within the broader context. However, the authors also made efforts to ensure, during data analysis, that the themes captured were brought out by the participants, and not merely themes that were aligned with their values. In order to manage this, they presented the research for feedback at Irish and international seminars and conferences, sought and incorporated guidance from the project’s International Advisory Committee and held regular discussions with the broader research team.

It is important to note that where participants have made statistical claims within these quotes, we have not triangulated them, as we wanted to acknowledge the participants’ expertise in the area and beliefs rather than focus on the veracity of particular statistics.

Results

Participants highlighted a number of factors that acted as barriers or facilitators to reform implementation – while one factor – the COVID-19 pandemic – acted as both (See Figure). Many of the barriers did not act in isolation but in tandem with or in parallel to others. The findings around the

Table 1. Participant Characteristics

Participant Organisation	No. of Participants
Health service executive management	2
Department of Health	4
Department of the Taoiseach (Prime Minister)	2
Department of Public Expenditure & Reform	1
Senior policy analyst	2
Senior healthcare professional	3
Public engagement consultant	1
Public health insurance sector	1

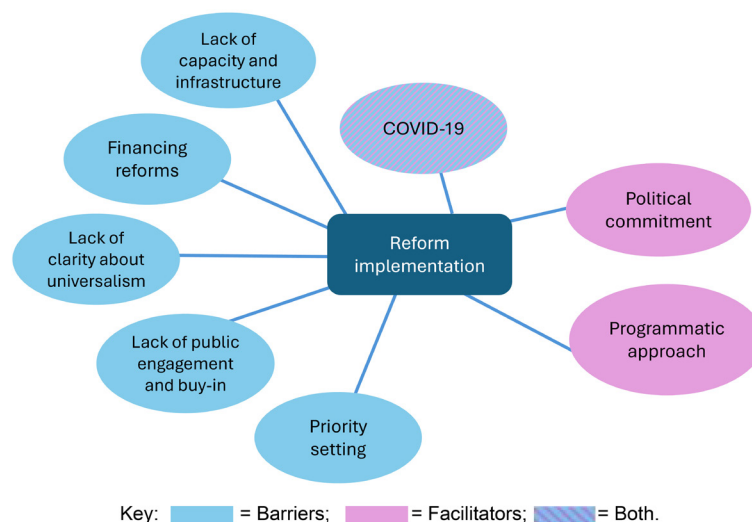


Figure. The Barriers and Facilitators to Reform Implementation.

barriers will be presented first, followed by the factors that facilitated implementation.

Barrier 1 - Lack of Capacity and Infrastructure

The data indicate that a lack of both capacity and infrastructure within the Irish health system has posed a significant barrier to the implementation of Sláintecare reforms. In particular, participants suggested a lack of capacity in relation to information technology (IT)/digital health and healthcare workforce, as well as general capacity issues, have acted as a barrier to implementing reform.

For example, Participant 13 said:

"To enable all these [digital health] solutions to work, we need to have Wi Fi in all our buildings. Less than 10% of the health infrastructure at the moment has Wi Fi. ... So, it's hundreds and hundreds of millions, so the level of investment – and that's just the infrastructure."

Participant 12 added:

"In the modern world, the fact that they haven't got further along on the IT/e-health journey is definitely a barrier. ... it's getting better but the idea of paper files floating anywhere is madness."

A lack of workforce capacity also posed a barrier to reform implementation. Discussing population growth, Participant 5 said:

"Demand is higher than we had anticipated... staff limitations of people working on the ground as well, struggling to meet current demand, and then, with many of the reforms, it's going to increase demand."

Participant 4 added:

"I think another issue that is going to make it challenging to implement Sláintecare is the workforce side of things. ... just actually getting the people in to do that is going to be very challenging."

Participant 10 spoke of a lack of capacity within primary care:

"Have free GP access for everyone, but where are the GPs?"

Participant 9 also expressed concerns around capacity within primary care:

"If you don't have the workforce in place, that could start to create issues. And I think the GP workforce is probably still quite scarce."

Participant 5 suggested that along with workforce, wider capacity issues exist:

"We need to increase capacity, in terms of beds and the workforce, and we're making small increases but I'm not sure that we're going to do enough to even outpace the population growth to adjust to and to deal with the backlogs."

Barrier 2 – Financing Reform

Although the Irish health system has been historically underfunded, participants suggested that funding is now, generally speaking, available – but financing Sláintecare reforms while also maintaining existing health services, which must cater to an increasing and an aging population, has proved challenging. Adding complexity to this fiscal space was the COVID-19 pandemic, which will be discussed in a following section below.

For example, Participant 9 said:

"Probably a barrier is those competing demands on funds. So do you invest funds in existing service levels and just making sure that what we're providing at the moment can be maintained in the face of growing populations, aging populations?"

Participant 4 suggested that long-term funding has proved challenging:

"Has finance been a barrier? I suspect it has. ... I think in theory there was a lot of acceptance that we're going to have to increase our spending. But when push came to shove, I think there was a little bit of gritting of teeth in the Department of Public Expenditure. And as time goes on, the costs of implementation are increasing."

Meanwhile, Participant 1 highlighted the significance of the investment needed to fund large-scale reform:

"Sláintecare is the biggest structural reform in the history of the State. And I don't think that's understood. In any strategic reform, it needs investment to support the reform over a period of time."

Barrier 3 – Lack of Clarity Around Universalism and Universal Healthcare

Participants suggested that a lack of consensus around both a definition of universalism, as a normative principle, as well as the optimal mechanisms through which to achieve universal healthcare, has formed a barrier to the successful implementation of Sláintecare. Participant 9 spoke to the former, definitional, issue:

“I think maybe the lack of clarity on what universality is and the definitions around that might act as a bit of a barrier.”

Participant 6 added:

“That debate and discussion around universal healthcare ... I think there may be different interpretations of, well, what do we mean?”

Participant 5 agreed, adding that there also exists a lack of clarity around the best mechanisms for implementing universalism, that is, optimal strategies for achieving universal healthcare as a policy target. They said:

“If you’re going to get 100% coverage in five years’ time, do it whatever [way] is the easiest, which is probably via age. But if you’re going to do it halfway, then you’re going to get us stuck, because there’s going to be an economic downturn. Then you need to do it via income, but uptake is lower, and there’s people not applying because of that stigma.”

Participant 8 also spoke to this issue:

“There’s definitely examples you can point to of eligibility expansion, but it hasn’t been done by saying, either we’re going to increase it for this group of people or for this basket of services. It’s been both. And it seems like it’s not part of a wider thought that says that this is what the end goal is.”

Participant 12 also urged a considered approach:

“They started saying, we give this free, we give that free, under sixes, under eights, under 12s, over 60. You know, it was a few free things. We were like, yes, they’re universal. But if you want to do something really universal, is that what you’d do? So, I think there was a moment where [some] said, Can you ... think through, where do we want to go next? Because all this stuff costs.”

However, Participant 1 suggested it might still be possible to achieve universalism, if there was the political will to do so:

“I think it is the right thing to do is to have free access for healthcare. Just different parts of the system will perceive it differently. It’s a really tricky one. But not insurmountable, if the real political intent is there.”

Barrier 4 – Lack of Public Engagement and Support

The importance of communication with and to the public by politicians and health system leaders was a recurrent point raised by participants, who suggested that a lack of public engagement around Sláintecare has acted as another barrier to implementation. This lack of engagement, when considered alongside the lack of public understanding of, and support for, Sláintecare suggests a chicken-and-egg dynamic regarding public and political opinion. This in turn generates questions about *who* and *what* needs to be involved in generating public “buy-in” for Sláintecare reforms.

Participant 14 highlighted the importance of communicating

reform objectives to the public:

“You need clarity as to your objectives. And I think they have to be things, one, obviously, that you can deliver, but two, that can show, quote, unquote, ‘meaningful change.’ And the third is, you do need to communicate that. And I think they weren’t great at communicating it.”

Reflecting on the time when Sláintecare was first launched, Participant 11 suggested:

“I would have built a real civic society movement behind Sláintecare. ... trade unions should have been engaged. ... civic society in general, even sporting organisations, which are very important in Ireland ... Have champions for it, people who were respected in various fields, people who came from different backgrounds, saying, actually, this is really good.”

Some participants suggested that public understanding of and thus potential buy-in around Sláintecare has proved challenging because of a conflation with other health system issues and media narratives around those. Participant 3 observed:

“I think the public find it very hard to separate out the Children’s Hospital from Sláintecare, from the HSE, from the Department of Health – there is an understandable conflation and confusion.”

Cultural and historical factors also seem to inform the public’s response to Sláintecare. For example, Participant 5 suggested there can be a lack of buy-in for universal healthcare among the Irish public who, due to cultural and historical factors, can remain “suspicious” of free healthcare:

“It’s not in our culture to have free GP care for everybody. ... I think there is nearly a suspicion of it.”

Participant 10 also spoke of a lack of public buy-in around community care, another key focus of Sláintecare, also due to cultural and historical factors:

“We’ve had a very hospital-centric approach for so long that actually trying to change that in people’s minds [is challenging].”

Barrier 5 – Maintaining Focus and Setting Priorities

A further barrier to implementing Sláintecare suggested by our participants can be framed in terms of the difficulties of maintaining momentum through introducing smaller changes while also maintaining focus on broader goals and systemic reforms needed to achieve those.

These tensions were articulated by Participant 15:

“I think we’ve done a lot of the stuff, although in many respects, we began with the easiest items, or the low hanging fruit, and then some difficult, impressive stuff has been done. But I think some of the thorny issues, which are the more difficult boxes to tick, haven’t been achieved.”

Participant 8 concurred, suggesting that while they understood the logic of prioritising some issues over others, bigger ones were not dealt with at the start of the implementation process and this ultimately impeded progress:

“They went for some of the smaller components of Sláintecare and they didn’t grasp the nettle of the really thorny issues like eligibility reform or the consultant contract or pulling private practice out of public hospitals. Those are the really meaty, difficult issues ... I understand the thinking

at the time. ... But if I were going back again, I don't know if that's what I would advise. I think you had to kind of grasp the nettle a little earlier than we did."

Participant 5 echoed this sense that while progress is being made on certain aspects of Sláintecare, the necessary broader reforms have not yet taken place:

"They've picked out some pieces and done those, but they've moved very much away from the overarching aim of the whole-scale reform of the healthcare system."

Our participants attempted to understand and explain the reasons underlying the prioritisation of certain aspects of Sláintecare over others, indicating that strategic, political, and temporal dynamics may be at play.

For example, Participant 7 suggested:

"There's a greater emphasis on certain things being delivered, the more politically attractive things ... It's not that anything ever really seems to fall out of it, but it's certainly de-prioritised and pushed out."

Participant 2 added:

"Part of the problem is that there's a huge public and political interest in the health system. So there tends to be a focus on the visible immediate actions, deliverables. So, the behind-the-scenes stuff that needs to get done, and I call them foundational blocks, there's not that much interest in them. They don't get a lot of focus, they get overlooked in some instances, because we do have finite resources. So, we tend to focus on the visible manifestations of Sláintecare."

These challenges around maintaining focus on the larger issues collectively formed a barrier to reform, particularly in relation to "thorny," politically sensitive and systemic issues.

Barrier 6 – The COVID-19 Pandemic

Participants suggested that the COVID-19 pandemic acted as a barrier, but also as a facilitator, to reform implementation. It posed barriers by redirecting resources and attention away from reforms and onto the immediate challenges presented by the pandemic. These aspects will be presented here, while the ways in which the pandemic acted as a facilitator will be presented in the subsequent section.

Participant 11 spoke succinctly of the impact that the pandemic had on Sláintecare:

"We probably could have done a lot more if COVID-19 hadn't happened."

Participant 5 said:

"The COVID-19 pandemic obviously had a fairly significant impact in that it changed people's focus away from reform to the immediate impact of the pandemic."

Participant 10 said:

"In the last four years, it was difficult in that everyone was so focused on COVID-19. And even then, even if they weren't directly involved in COVID-19-related functions, they were down two or three colleagues in each unit. And the focus was very much on the day job."

Participant 13 said:

"I think COVID-19 derailed things ... so everything else became secondary."

They added that the pandemic negatively impacted the health workforce, with ramifications for reform:

"I think when we came out of COVID-19, although we're still doing a lot of things, people had two to three years of just full-on, seven days a week, carrying the can. And I think at a human level, that's had an impact."

Participant 2 also spoke of the impact on the workforce:

"In terms of COVID-19 – people were exhausted afterwards. And unfortunately, [some] said, Look, we've beaten COVID-19. Now, let's fix the health system. And people were saying, God and Jesus, can you give me ten minutes while I catch my breath? That didn't help. I think we probably should have actually just paused for a couple of months at least, regrouped, reimagined and re-planned what we were going to do."

However, the pandemic also enabled implementation. This, and other facilitators, will be discussed below.

Results – Facilitators

At times, the facilitators to reform mirror the barriers but at other times they move beyond these factors. These key enablers will be presented below.

Facilitator 1 – Political Commitment

Participants suggested that political commitment was key to reform implementation, as was leadership across both political and health system spheres.

Many participants suggested that Ireland's political all-party consensus around Sláintecare has been crucial to its success and makes it stand out as an example for other countries, where there is often not the same buy-in across all political parties. For example, Participant 1 said:

"The fact that it had a cross-party agreement and a cross-party mandate was beneficial. So, you weren't going in to debate that, at [parliamentary] committees, the rationale for it – they had established that was it."

Participant 14 said:

"It was thought that it would be important to try and produce it as an all-party report, and that was done. That was very important."

Participant 13 said:

"The thing that has made it successful, the biggest one, is the political commitment ... The fact that all the parties signed up to it ultimately has been a huge plus. It gives a different dialogue or conversation between [the HSE] and the political system. ... it means collectively, on most of the major areas, there's a broad consensus."

Thus, our data suggests that political consensus and commitment facilitated reform progress. Other facilitators will be discussed below.

Facilitator 2 – Balancing the Parts and the Whole: Programmatic Approach and Prioritising

Participants suggested that while Sláintecare outlined a long-term vision for the health system, the programmatic approach taken by health system leaders to implementation has facilitated reform work. For example, Participant 10 said:

"I think it's [Sláintecare] evolved quite significantly. We now have a very strong and very systematic programmatic approach to it."

Participant 8 concurred:

"In order to do it, you have to be programmatic, because you'd take tiny steps forward otherwise, if you were trying to bring all things together at the same time, so you have to break it down."

Participant 13 suggested that within this programmatic approach, health system leaders have broken down the large-scale reforms into achievable targets:

"Like anything of scale, you have to break it up in some way. Yes, you can then be accused, from a very Puritan perspective, that you're not moving forward with totality. ... To a point, I agree, but I think you have to have priorities. There's a number of things on the starting line and you're going to move some things along faster than others. ... As I always say to people, you have 100 chips in the casino, so where are you going to put the 100 chips?"

Thus, for many participants, an incremental, programmatic approach to implementation helped facilitate reform.

Facilitator 3 – The COVID-19 Pandemic

As mentioned above, COVID-19 acted as a barrier to implementation. Data in relation to the ways in which it also facilitated Sláintecare progress is outlined below.

Participant 1 said:

"I think COVID-19 accelerated a lot of the reforms of Sláintecare. ... people had the mandate, they felt they had it, and they took it. They embraced it. And ironically enough, even if you put a cyber-attack on top of that^[1], they had to just act locally and build new processes and everything."

Participant 13 said:

"I think COVID-19 did open barriers across community and hospital much better, it showed what the system could do when it got focused on, albeit a single issue, what it could achieve working together."

Participant 14 said:

"I think COVID-19 helped in a strange way, to give a further boost to some of the work of Sláintecare. If you needed evidence that we needed to have further reform, COVID-19 showed that."

Participant 5 said:

"A lot of policies that were introduced were in line with what was in Sláintecare. And I think that in a wider context, that can be quite useful, that you have this shock, and it makes people focus on the need for universality."

Participant 12 added:

"There were some big developments that happened during COVID-19. There was a sense that if all the breaks are off, that the HSE actually can do big."

Thus, COVID-19 also facilitated reform implementation, demonstrating the need for universal healthcare and that reform was possible within the Irish system. All-party support for Sláintecare, as well as a practical, programmatic approach to implementation, also facilitated reforms (See Table 2 for a summary of results presented above). This data, and our other results, will be discussed below.

Discussion

The Irish case study of national healthcare reform, which includes the introduction of UHC, reflects many of the international experiences highlighted in our realist review,

Table 2. Summary of Results

Finding	Description	Illustrative Quote
Barriers		
1. Lack of capacity and infrastructure	A lack of capacity and infrastructure including but not limited to healthcare workforce, digital health and hospital beds.	Participant 10: <i>"Have free GP access for everyone, but where are the GPs?"</i>
2. Financing reform	Planning and earmarking revenue to fund and sustain reforms, while maintaining current health services.	Participant 9: <i>"Probably a barrier is those competing demands on funds."</i>
3. Lack of clarity around universalism and universal healthcare	A lack of consensus around a <i>definition</i> of universalism and around <i>optimal mechanisms</i> through which to achieve UHC.	Participant 6: <i>"I think there may be different interpretations of, well, what do we mean by universalism?"</i>
4. Lack of public engagement and support	An absence of engagement with the public, along with cultural and historical issues impacting public support.	Participant 14: <i>"You do need to communicate your objectives. And I think they weren't great at communicating it."</i>
5. Maintaining focus and setting priorities	This captures the challenges of supporting momentum through introducing smaller changes while also maintaining focus on systemic reforms.	Participant 5: <i>"They've picked out some pieces and done those, but they've moved very much away from whole-scale reform of the health system."</i>
6. The COVID-19 pandemic	The impact of redirecting resources away from reforms and onto the immediate challenges of the pandemic.	Participant 13 said: <i>"I think it COVID derailed things, so everything else became secondary."</i>
Facilitators		
1. Political commitment	All-party support for Sláintecare and leadership in relation to its implementation.	Participant 1: <i>"Having cross-party agreement was beneficial. You weren't going in to debate the rationale for it."</i>
2. Balancing the parts and the whole: Programmatic approach and prioritising	Taking a programmatic approach to reform implementation.	Participant 8: <i>"In order to do it, you have to be programmatic, you have to break it down."</i>
3. The COVID-19 pandemic	This crisis acted as a catalyst for positive change and reform implementation.	Participant 5: <i>"You have this shock, and it makes people focus on the need for universality."</i>

Abbreviations: UHC, Universal health coverage; GPs, general practitioners.

but also offers additional insights which can be useful to countries attempting to implement similar reforms.³

Given its colonial past and historical poverty, coupled with more recent economic strength, active membership within the European Union and a strong private health insurance sector, the case study of Ireland offers lessons that can be useful for both low- and middle-income countries (LMICs) and high-income countries (HICs) when implementing UHC reforms. For example, a lack of health system capacity and infrastructure has been a significant barrier to UHC reform implementation internationally, with Derkyi-Kwarteng et al suggesting that implementation gaps exist when health systems lack the capacity and cohesion to deliver on UHC commitments.^{3,21} Across LMICs, as well as post-colonial countries such as Ireland, lack of capacity has often been the result of a lack of financial resources due to historic underfunding, poor national economies and/or colonial legacies.^{4,13,22,23} Meanwhile, for some countries, such as Ireland, that were wealthy compared with the Global South but less so in relation to other European countries, austerity measures taken in response to the economic crisis of 2008 led to further workforce shortages and a lack of healthcare facilities and services.²⁴ Within this context, our study participants indicated that an existing lack of infrastructure and an overburdened health system posed a significant barrier to universal healthcare reform implementation in Ireland (it is important to note that since interviews were conducted, the Irish health system has made strides in building its digital infrastructure and services, including the launch of the HSE's Patient App). The private health insurance sector in Ireland has, over the last two decades, achieved high coverage in part because of this lack of capacity within the public system, promising clients the ability to "jump the queue" and receive treatment more quickly. This echoes the experiences of other countries, seen in our realist review and other research, where a weak public health infrastructure has meant patients must turn to private insurance or out-of-pocket payments to access care.^{3,21,25} The implications of this on reforms in Ireland and other countries merits further investigation.

Alongside the impact that limited funding for the public health system has on capacity, challenges around securing sufficient financial resources for reform while also maintaining existing services were highlighted by our participants. This finding adds additional insight into challenges around the financing of health system reform, and adds weight to our previous research, which suggests that revenue raising and equitable pooling and purchasing mechanisms remain some of the most challenging aspects of UHC reform, across both HICs and LMICs, with the latter facing more restrictive fiscal spaces.³ The lessons from Ireland add weight to the international evidence suggesting that countries must plan for and earmark funding for both ongoing services as well as reforms, particularly when revenue is limited, if UHC reforms are to be implemented.

Our study participants suggested that a lack of unity around a definition of universalism and around optimal mechanisms for implementing universal healthcare, has acted as a barrier to Sláintecare implementation. Universalism was an explicit

goal and a critical component of the original Sláintecare report and expansion of access has taken place under recent reforms. However, our study indicates that a cohesive, normative definition of universalism, as well as consensus around policy and budgetary mechanisms for achieving or moving towards universal healthcare, has yet to be produced. This has perhaps watered down a commitment from politicians, policy-makers and health system leaders to universalism, perhaps concerned about costs, as indicated by Participant 4. This finding adds further weight to other Irish studies, with participants from Mac Conghail et al suggesting that UHC lacks a shared or stable meaning within the Irish health system.²⁶ Potential reasons underlying these varied definitions would shed further light on these issues.

A lack of consensus around universalism and universal healthcare is mirrored in the experiences of other countries and in international discourses.^{3,27-29} However, our participants add nuance to this discussion by highlighting the importance of clarity and consensus around mechanisms for the introduction of universal healthcare. Significantly too, some participants draw a link between politics and consensus, suggesting that if the political will to do so existed, consensus around the definition of and mechanisms for UHC could be reached.

The beneficial role of political leadership and commitment to reform is highlighted both by our participants and in other international studies, with political support playing a crucial role in the introduction or implementation of health reforms.^{1,30-32} Specifically, our realist review indicates that UHC reforms can be facilitated by political vision, conviction and commitment to UHC goals, and cross-party consensus significantly facilitates long-term political commitment to UHC implementation.³ Our participants highlighted political consensus as a significant facilitator of reform implementation in Ireland. Specifically, in Ireland, this has meant that while disagreements may exist around implementation, all political parties committed to the reforms in principle, providing some protection to them beyond election cycles and daily political in-fighting. Lessons from this finding around political commitment are applicable to both HICs and LMICs attempting to reform their health systems.

In other countries, the political will and public engagement around health reform often emerged from socio-political contexts that were ripe for change, bringing in health reforms as part of larger civil rights reforms or driven by popular demands from newly enfranchised voters.³³ This was seen in many European countries and Canada following World War II and, later, in Latin America.³ In contrast, this has not been the case in Ireland.

Because reforms were not mandated within a broader social movement, communication with the public was perhaps all the more important to engagement and buy-in. However, some of our participants suggested that health system leaders and politicians did not adequately communicate the goals and objectives of Sláintecare with members of the public, or mobilise civic leaders to engage around these topics. This lack of communication and engagement, coupled with a perceived conflation of other health topics present within political

discourse and media narratives, has contributed to a lack of understanding and buy-in from members of the public. This finding builds on our realist review, and suggests that for other countries implementing UHC reform, clear communication with the public around reform goals and objectives is key to engagement and buy-in, particularly in contexts where health reforms are not occurring within broader social movements or in response to significant geopolitical crises.

Furthermore, two historical-cultural factors have also influenced public buy-in, according to participants. One factor is that due to the historically hospital-centric organisation of the health system, members of the public are more familiar with this system than one that is centred on a strong primary care sector, though this could be shifted with time. The second factor, that of a cultural preference for paying for healthcare in Ireland, could potentially be less relevant to other countries where social solidarity is stronger, though perhaps research into other post-colonial health systems might yield similar results.

Our study adds new insights to international discourses on reform implementation through our findings around priority setting and the programmatic approach. Many participants praised the ambition and vision of Sláintecare, suggesting that the large-scale reforms are necessary to bring about true, whole-system reform. In contrast to other countries, such as Finland,³⁴ Ireland has taken a programmatic approach to reform implementation, establishing governance structures to facilitate a step-by-step approach. This included the establishment of the Sláintecare Implementation Advisory Council, a 21-member committee that advised the Sláintecare Programme Implementation office from 2018–2021. The work of this council was then continued by the Sláintecare Programme Board, which is co-chaired by the Secretary General of the Health Department and the CEO of the HSE, to facilitate collaboration and coordination.

The symbiotic issues of priority setting and a programmatic approach are distinct – and, for our participants, represented a barrier in the first instance and a facilitator in the second – but are none-the-less closely interlinked. Many participants suggested that a programmatic approach to a health reform as broad as Sláintecare is both desirable and unavoidable, reflecting reality and offering the only practical approach to big reform implementation. However, others suggested that the inevitable prioritisation of or focus on some aspects of reform over others, which were then implemented as part of this programmatic approach, meant that at times whole-scale reform and significant aspects of the original Sláintecare report were not implemented. Furthermore, the original Sláintecare report includes an explicit sequencing logic which is missing from the current incremental approach.⁹ Our findings in relation to these tensions and challenges builds on previous Irish research, which suggests that Ireland's approach to reform has been characterised by uneven and slow implementation.^{4,9,26}

Our study also adds new insights into some of the ways in which a shock can act as both a barrier to and facilitator of reform. As a barrier, the COVID-19 pandemic syphoned financial and human resources away from Sláintecare, and

built up a backlog within non-COVID-19 care that then affected the health system's capacity to deliver reforms. It also stalled momentum and appetite for reform. This latter point has been reflected in other crises, such as the financial crisis of 2008 (and ensuing bailout from the Troika (European Union, the European Central Bank, and the International Monetary Fund) for five European countries, including Ireland). Barry et al, for example, found that government priorities for reform, even when shared by healthcare managers, were afforded little managerial time due to the pressures of ensuring service delivery during the economic crisis.³⁵

However, the pandemic also acted as a facilitator to reform implementation. For example, the release of national funding and easing of EU debt rules during the pandemic allowed health service leaders to fund COVID-19-related services, while also building health system capacity that could support long-term reform goals.⁹ Furthermore, certain (COVID-19-related) services were universalised and frontline workers were often empowered to make decisions.⁵ Thus, while presenting challenges, crises such as the COVID-19 pandemic can also offer opportunities for reform. This can be seen in the experiences of other countries, such as the Ukraine, where there may be opportunities to continue structural reforms, as the country attempts to rebuild its health system in the face of war.^{36,37} This finding also echoes historical experiences of other countries throughout the 20th century, with many in Europe making progress towards universal healthcare in the form of national health services within the context of a desire for social cohesion following World War II.³

Other research indicates that, in Ireland, political commitment to addressing population health needs during the pandemic was crucial to the progress made in relation to overarching health reform.⁵ This links back to the facilitation role that political commitment plays in reform implementation. It also suggests that perhaps there is the potential for rapid reform when a crisis galvanises political support for such changes.⁵

Limitations

Elite interviews provided key insights into the national implementation work of Sláintecare. However, further research into the lived experiences of junior frontline workers, as well as patient representatives and members of the public, would provide a greater understanding of the barriers and facilitators to implementation. Furthermore, the issues of decentralisation and public-private dynamics are key aspects of international health reforms, and Sláintecare is no different. As mentioned in the introduction, these two substantial issues are outside the remit of this paper. However, understanding them is essential to gaining a complete picture of the Irish case study. While a number of cultural and historical factors make Ireland somewhat of an outlier in Europe in terms of healthcare provision, the country grapples with many of the same issues that others do, such as expanding access and financing for an ageing population, thus making lessons from this case study applicable in other contexts. Finally, utilising our realist review as a framework has enabled us to test it within the case study of Ireland. This has confirmed

many of the international findings of the realist review while also adding additional insights. However, utilising other frameworks would enable understanding of the same topic from a different perspective.

Conclusion

Examining international experiences of UHC reforms provides learning on the mechanisms that support or hinder implementation processes. Examining the case study of Ireland in light of these international findings helps to crystalise these learnings and deepen our understanding of the barriers and facilitators to implementation, bounded by a particular context. Our findings confirm that a lack of capacity and infrastructure in the health system, as well as strained financial and workforce resources, form significant barriers to reform implementation, as does a lack of communication with the public. Furthermore, while a programmatic approach to the implementation of large-scale reforms is useful, the over-arching goals of the reforms must not be lost or sidelined due to political maneuverers or the cherry picking of components. However, strong communication and political consensus can greatly facilitate reforms, even where there is limited public engagement and the lack of a social movement to support UHC. Finally, while acute crises such as the COVID-19 pandemic can stall reforms, they can also act as catalysts for positive change and reform implementation. These learnings can empower policy-makers and health system leaders across LMICs and HICs by providing lessons for reform implementation.

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Disclosure of artificial intelligence (AI) use

The authors declare that no AI was used to research, write, draft or revise this article.

Ethical issues

Ethical approval was granted by the Trinity College Dublin, Health Policy and Management and Centre for Global Health Research Ethics Committee.

Conflicts of interest

Authors declare that they have no conflicts of interest.

Authors' contributions

Conceptualization: Liz Farsaci, Mary Guy, and Steve Thomas.
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Formal analysis: Liz Farsaci and Steve Thomas.
Funding acquisition: Steve Thomas.
Investigation: Liz Farsaci and Steve Thomas.
Methodology: Liz Farsaci and Steve Thomas.
Project administration: Liz Farsaci.
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Supervision: Steve Thomas.
Validation: Mary Guy and Steve Thomas.
Visualization: Liz Farsaci and Steve Thomas.

Writing—original draft: Liz Farsaci.

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Data availability statement

The authors confirm that data supporting the findings of this study are available within the article (anonymised excerpts from transcripts) or as [Supplementary files 2 and 3](#) (interview guide, coding tree). However, full transcripts are not publicly available due to restrictions outlined in consent agreements with participants and the identifying nature of the data. These transcripts are stored on a password protected computer stored securely at the Academic Institution, per Institutional guidelines.

NVivo 12 qualitative analysis software was used to assist in data analysis. Initial coding tree and codebook were co-designed by lead author and principle investigator. Inductive codes were discussed with research team during data analysis. Lead author led coding, with a subset coded by the principle investigator to ensure agreement and support rigour and transparency.

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Endnotes

^[1] In May 2021 a cyberattack (which occurred in the middle of the third wave of COVID-19), shut down the IT system of the Irish public health service, bringing disruptions and delays to service provision.⁶

Supplementary files

[Supplementary file 1](#). Illustrated Findings and CMOCs.

[Supplementary file 2](#). Interview Guide.

[Supplementary file 3](#). Coding Tree.

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