

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

Journal name: International Journal of Health Policy and Management (IJHPM)

Authors' information: Liz Farsaci^{1*}, Mary Guy², Steve Thomas²

¹School of Nursing and Midwifery, Trinity College Dublin, Dublin, Ireland.

²Centre for Health Policy and Management, School of Medicine, Trinity College Dublin, Dublin, Ireland.

***Correspondence to:** Liz Farsaci; Email: farsacil@tcd.ie

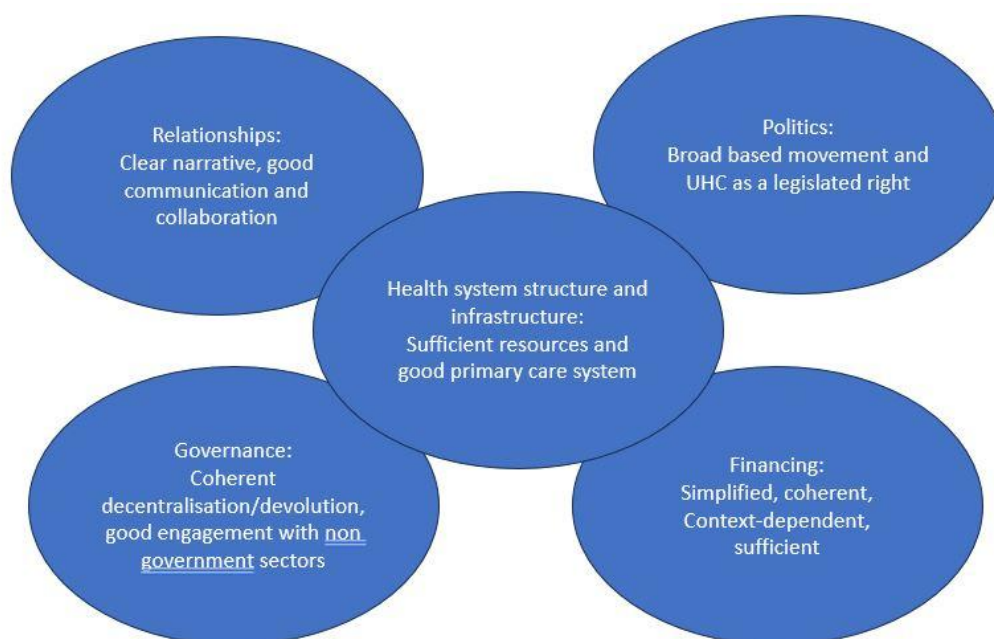
Citation: Farsaci L, Guy M, Thomas S. Barriers and facilitators to national UHC health reform implementation: a qualitative case study of Sláintecare in Ireland. Int J Health Policy Manag. 2026;15:9733. doi:[10.34172/ijhpm.9733](https://doi.org/10.34172/ijhpm.9733)

Supplementary file 1. Illustrated Findings and CMOCs

Illustrated Findings and Context-Mechanism-Outcome Configurations from

Farsaci L, Fleming P, Caffrey L, Belle SV, O'Donoghue C, Almirall-Sanchez A, Mockler D, Thomas S. *Barriers and Facilitators to International Universal Health Coverage Reforms: A Realist Review*. International Journal of Health Policy and Management. 2025;14:8709.

Findings and knowledge contribution within the themes:



Context-Mechanism-Outcome Configurations

Theme 1: Strong Governance

CMOC 1: When service provision is decentralised without adequate funding or sufficient devolution of power or in countries where capacity and wealth vary significantly between regions, a lack of budget control and limited decision-making power at a local level or a lack of integrated planning between national and local authorities can lead to fragmented service provision and financial pathways, and a lack of coverage, particularly for marginalised groups.

CMOC 2: When reforms do not address legacy issues such as resource constraints or weak infrastructure, when they are implemented through a top-down, centralised approach or when centralised management is out of touch with local needs, a lack of participatory, local decision-making and buy-in for reforms can act as a barrier to implementation.

CMOC 3: When civil society and community organisations are involved in decision-making about healthcare and local services have the resources and authority to deliver reforms then decentralisation or a devolution of centralised power structures can strengthen social participation and thus facilitate UHC reforms.

Theme 2: Financing

CMOC 4: If financing pathways are overly complex or fragmented or if there exists a lack of adequate revenue or inequitable mechanisms for revenue collection then services are fragmented and a disparity between policy commitments and service delivery is created because technical design of funding mechanisms remains challenging and optimal financing mechanisms for reforms remain unclear.

CMOC 5: Sub-optimal pooling and purchasing arrangements and inadequate provider incentives influence provider behaviour in treatment decisions. These decisions in turn affect equity in access and can lead to the introduction of out-of-pocket payments for service users, a denial or rationing of services and longer wait times.

CMOC 6: On the service user end, when designing and implementing UHC policy, premiums must be made affordable and there must be an equitable distribution of entitlements. Otherwise, there is unequitable access and a lack of financial protection/continuation of OOP payments, particularly for non-urban and marginalised groups.

Theme 3: Health systems structure

CMOC 7: In countries whose public health systems are under-resourced or fragmented, a lack of resources or capacity means that the system is unable to deliver the breadth of services outlined in the UHC policy, creating a policy implementation gap and often forcing people to seek care from the private system. Because of this, access to public services can be constrained, financial protection will be limited, and the private sector will be strengthened.

CMOC 8: For countries that want to introduce UHC, development of a strong primary health system can be used as a vehicle for achieving UHC.

Theme 4: Political Commitment

CMOC 9: Political context significantly affects the trajectory of reforms, supporting or undermining implementation of UHC. The presence of a strong social movement that advocates for broad reforms and a multipartisan political consensus that supports and/or political commitment to the underlying values of UHC can facilitate sustained support of UHC reforms across the civil service and political parties and protect the reforms beyond election cycles.

CMOC 10: In a social context in which healthcare is valued as a human right or public good and not conceptualised as a commodity or linked to capacity to pay/employment status, enshrining universalism within a legal/constitutional framework can provide a foundation that helps to hold governments accountable and protect reforms against the changing political agendas.

Theme 5: Communication and Relationships

CMOC 11: When a government is committed to implementing health reforms, a clear narrative around what the reforms involve, meaningful engagement with the public and stakeholders working in the public health system – including clear communication with the population and frontline workers about what the reforms mean for them – can contribute to the advancement of reforms.