Health, Morality, and Moralism

The Irish Healthcare System: A Morality Tale

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Abstract: A country's healthcare system—the protection and healing of some its weakest people, its sick and injured—could be considered to be one of the most definitive expressions of its national morality. In recent decades, Ireland has experienced profound cultural changes; from a mostly monocultural and religious society to a multi-ethnic one, where secular ideas predominate. Economically, it is largely neoliberal, with one of the world's most open economies, and one of its lowest corporate tax rates; though there is also a welfare state. Its healthcare system has reflected these cultural changes. The system has evolved, gradually, from being run almost exclusively by religious groups, to becoming essentially secular in nature (though religious groups are still involved at the ownership level). Overall, the system is run according to the two competing secular ideologies which currently predominate; it is a two-tier system, with a mix of a neoliberally oriented (though government subsidized) private system, and a public system. The latter has been starved of resources in recent decades; so to achieve good, or at times adequate healthcare, it is almost essential to have private health insurance (which about half of the population have).

This two-tier system has led to significant concerns and occasional scandals; for example, patients dying while on waiting lists for public treatment, who could have been treated and possibly saved if they had health insurance. A purely ethical approach to healthcare—with the aim of healing the sick—has been mixed with competing motives, such as the desire for profit in the private sector, or for short term savings and box-ticking in the public system. Thus, good healthcare practice and best moral practice are being undermined by competing agendas.

In this article, I describe and reflect ethically on the Irish healthcare system, and how it has evolved to its current state. I also discuss how dysfunction in the healthcare system, leading to the death of a pregnant woman, Savita Halappanavar, was a major factor in a constitutional ban on abortion being overturned.

Keywords: Irish healthcare system; Ireland; morality; ethics; abortion referendum; Savita Halappanavar; neoliberalism; health insurance; Catholic Church

Introduction

> The Irish healthcare system seems to be in permanent crisis. The symptoms are manifest: too few beds and staff, long waiting lists, patient care which fails to conform to the standards expected in one of Europe's wealthier countries. What is less readily apparent is that Ireland has a healthcare system that almost defies rational analysis. The Organisation for Economic Co-Operation and Development (OECD) has diplomatically described the Irish health care system as "unique." Others might consider its mix of the public and private, its state-funded institutional inequity, as bizarre.
>
> Maev-Ann Wren[1]

On the surface, the Irish healthcare system appears similar to that of other developed European countries. (To avoid confusion: this article is about the Republic of Ireland; not Northern Ireland, in which Britain's National Health Service (NHS) is in place.) There is a spread of hospitals, of varying vintages, around the country's cities and towns. These are backed up by clinics, primary care doctors in general

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practice (GPs), public health nurses and other standard supports. The major hospitals have university affiliations. Medical school selection is extremely competitive, and training is lengthy and rigorous. Many doctors obtain further training and work experience overseas. Most nurses are educated to degree level. The medical staff are multinational. Yet, due to a combination of factors, both internal and external to the health service, it frequently scores low in outcomes, and is plagued by regular scandals.

In 1987, Ruth Barrington published a political history of the healthcare system: its opening sentence was: "How did we come to have one of the best health services in the world?"[2] That seems unlikely to be written now. Since the mid-1990s, media reports have abounded with stories of great dysfunction in the system; frequently, there is near-chaos in hospital accident and emergency departments, with sick and injured patients languishing on trolleys, chairs or the floor for many hours before being attended to; long waiting lists, sometimes stretching to years, for routine investigations and procedures; and unending stories of neglect of patients, cover-ups of errors, and bad practice.

A selection of newspaper headlines from July to September 2018 give a flavor of the coverage: *Children's hospital apologises over death of baby;*[3] *3,000 women may be caught up in cervical cancer scandal;*[4] *Doctors say emergency departments are 'death zones' due to overcrowding;*[5] *Water withheld as 'punishment' from patients at Mayo mental health facility;*[6] *Cancer patients chased by debt collectors;* [7] *Summer nightmare for patients as 8,000 are forced to wait on trolleys.*[8] *'Our hospitals will be war zones once winter comes' – nurses' warning about A&E chaos.*[9] Headlines like these appear on a near-daily basis.

One newspaper article described how an emergency department physician complained of how a 91-year-old man had been left on a trolley for 24 hours. The man was without privacy and exposed to constant noise and light during that time. In the same hospital, a 101-year-old woman had recently been on a trolley for 26 hours; and another patient 59 hours.[10,11] There are passionate radio phone-in shows and TV discussions, where people describe their bad experiences. Social media is filled with similar complaints. For example: "Only informed yesterday that my father would have to wait 14 months for MRI after a significant cancerous tumour found. Let out of hospital twice despite months of torturously watching our father sick and voicing concerns..."[12] My own family had an experience where my late uncle was admitted to hospital from a nursing home with a stroke in 2016; aged 91. He spent approximately 24 hours on a trolley in a busy corridor. He was not examined in that time, or even given food or water. Had a family member not been with him, he would probably have died. Nursing home staff told him later that such experiences are common, and many of their patients choose not to go to hospital, even for strokes and other serious issues, because of such treatment; they could be safer and more comfortable staying where they were.

Confidence in the system is further reduced by the fact that media coverage is sometimes sensationalist, even hysterical, glorying in focusing on bad news and ignoring day-to-day successes.[13] Yet not all media coverage is sensationalist; much is accurate. Also, it is not just media painting a negative picture. Members of the medical and nursing professions frequently complain about the system's shortcomings. A doctor said to me: "we used to have a healthcare service;" which, while being an overstatement, is an illustration of how confidence in the health system has declined. Ray Walley, the 2015/16 president of the Irish Medical Organisation (IMO),

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the doctors' trade union, observed that there was a "crisis of morale"[14] among doctors, noting:

> ...we are being asked to deliver care in unresourced environments, with no supports and are constantly having to compromise quality of care...
>
> Is it really any wonder that the Irish health service is simply not an employer of choice, while other countries like Canada, the US, Australia and the UK are actively recruiting and encouraging Irish doctors to come and work in their healthcare systems?... It is a sad indictment of our public health services that only 22 per cent of trainees are committed to definitely stay in Ireland.[15]

The 2018/19 IMO president, Peadar Gilligan, has said that there are "more resignations from the public hospital system than ever before in the history of the State" due to the system's problems, that overcrowding in hospital A&Es "costs lives and must stop," and that storing admitted hospital patients on trolleys and chairs is "an absolute outrage."[16]

A professor of oncology and former senator, John Crown, wrote of the system: "people bring their political ideology to the table and then pick the health service which most closely matches it"; and: "We do not have the worst quality of healthcare in the developed world, we have instead the worst managed healthcare system in the developed world, run by technically deficient, medically illiterate bureaucrats... Had we the same demographics as other European States; we would have the most expensive healthcare system in the world."[17]

While in Britain, a survey which asked "what is the essence of being British" received as the most common answer "having access to the NHS,"[18] such an answer would not be given in Ireland. There is little loyalty to the system. The large amount of criticism it receives does not appear to cause meaningful change. The negative narrative has become part of the national consciousness.

Politicians make promises of reform regularly, which tend not to be fulfilled. For example, in 2006, the then minister for health, Mary Harney, declared a national emergency over the number of patients on trolleys in hospital emergency departments. Subsequently, the number went up, and is higher now; for in spite of the 'emergency,' the government cut the number of public hospital beds from 94 percent of the EU average in 2006, to 52 percent in 2010; which is still the approximate figure.[19] Generally, government attempts at improvement tend toward small adjustments to the current system, without deeper change.[20]

Many of the system's problems stem from its design; it is divided into two tiers, private and public, where access to care is largely determined by ability to pay, rather than clinical need. Both public and private care are government-subsidized. Public care tends to be inferior to private, and delays there can be very significant; sometimes with catastrophic consequences.[21] In the French-based advocacy and analysis group Health Consumer Powerhouse's *Annual European Health Consumer Index*, which evaluates the public health systems of 35 European countries, Ireland does comparatively badly in many areas; and for hospital waiting list times, it comes last among 35 countries studied.[22] An OECD study stated that Ireland's hospitals operate at close to capacity, and that waiting lists are long;[23] two of the system's main problems, from which many others flow.

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As well as its two tiers, it has also evolved in a piecemeal way, growing organically and without an overriding plan. It has been subjected to prevailing political ideologies and interest groups.[24] It must be asked: is it inevitable that a two-tier system will lead to worse treatment and facilities, and poorer outcomes for those on the lower tier? Perhaps one could argue the point; for other factors come into play, such as the ability and conscientiousness of individual healthcare professionals. Nonetheless, such a system provides an inherent bias toward better care for those who pay; and it has turned out that way, generally speaking, in Ireland.

In spite of the negativity which envelops it, the health system does function normally much of the time. There are frequent good outcomes, and many people do receive excellent care. But the receipt of good or adequate care can be haphazard; it can also vary widely between illnesses, as some branches of medicine are better resourced that others.

It is important to distinguish human error and failings from systemic problems. Our flawed human nature means there will always be errors and worse, even in the best systems. Margaret Brazier and Emma Cave listed 'negatives' in Britain's NHS (once seen as the exemplar of health systems). These included extreme rudeness, poor care, neglect of vulnerable children, surgeons with higher than normal death rates being protected, sexual assault, and even a medical serial killer, Dr. Harold Shipman, who is estimated to have murdered 215 or more patients.[25] All health systems (and all human systems) will contain suboptimal professionals, even where the system is well designed. Yet, Ireland's additional difficulty is that its healthcare system is problematic in itself.

A Brief History of Irish Healthcare (and the Roots of Current Problems)[26]

The first hospitals in Ireland appeared in the early 18th century, when the country was under British rule; this mirrored developments in Britain. Hospitals were founded largely by concerned voluntary organizations and philanthropists. Funding sources included public subscriptions and donations. Healthcare changed in the 19th century. The British government established workhouses for the very poor; grim places that provided a modicum of free healthcare. Larger changes occurred after 1829, when Catholic emancipation was granted by the British government. Before that, Catholicism had been legally persecuted and suppressed, forced underground; where it nonetheless persisted. Catholic emancipation ended legal suppression; the Irish Church flourished, quickly building large numbers of hospitals, schools, churches and other social organizations, in Ireland and around much of the world.

After Irish independence was gained in 1922, the new state was poor, trying to find its way in the world after centuries of colonial rule. The state did not set up a Department of Health or a Department of Social Welfare until 1947.[27] 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). Protestant churches also ran hospitals, in spite of being a small minority. Some hospitals were run at local government level.[28]

Socialized medicine became fashionable in Europe in the 20th century, particularly in the 1940s (though in Germany, Bismarck established a form of universal coverage in 1883, with compulsory health insurance for workers). In 1942, Britain proposed a National Health Service, which would be free to all at point of entry, and funded by taxes. The Irish government was influenced by this, and intended

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to found a health system where "there would be no more doctor's bills, no more chemist's bills, no more hospital bills, no more financial fear of ill health... a healthcare system that would be freely available to all who needed it."[29] This would seem to be a manifestation of morality at the highest level.

This health service was to be developed in stages. The first step toward it was to be a *mother and child scheme*. It proposed that free healthcare would be given to all expectant mothers, before and after birth, and to children up to the age of 16, without any income tests.[30] Uncontroversial, it would seem; even the name seemed heart-warming.[31] But it turned out to be very controversial, and led to the first conflict between Church and state since Irish independence. Two powerful groups opposed the scheme: the medical profession and the bishops of the Catholic Church. The government's own Department of Finance also opposed it.[32]

I will discuss the arguments of those opponents in a later section, *An Ethical Look at Ireland's Healthcare System*. Suffice it to say for now, that the mother and child scheme, and with it Ireland's proposed universal healthcare service, died under the weight of this opposition, in 1951. Instead, something quite different evolved. For those on lower incomes, a free or cheap, and largely inferior, system grew. Additionally, a state-supported health insurance company, Voluntary Health Insurance (VHI), was founded in 1957, allowing the wealthier to use private medicine to get better healthcare. This formalized the two-tier system that still exists.[33]

The health system changed over time, particularly regarding hospital building and structures of governance. In the 1970s, 'medical cards' were established. These were granted to the poorest, and still exist, allowing free access to public hospitals, primary care, and drugs.[34,35] Neoliberalism has come increasingly to the fore in Ireland since the mid-1990s.[36] Results include a consolidation of the two-tier system, which took place in 2001-2 , when the government introduced tax incentives for developers of private hospitals; this led to an increase in their number.[37] Insurers other than VHI have been allowed into the market; this has been followed by large increases in premiums, and an explosion in the number of policy types in each company; the latter making the purchase of health insurance very complicated.[38,39]

The Current Structure of the Healthcare System

It is worth mentioning that Ireland's healthcare is likely to be the envy of some poorer countries; but not so when compared with its peers. In practical terms, the first point of contact for a patient with the system is either a local primary care doctor, a general practitioner (GP) who can refer a patient on to specialists; or the accident and emergency system in a hospital. Most patients are required to pay for these.[40] After the initial contact, patients who need further treatment will be divided into one of two groups: those who have insurance, or who can otherwise pay the market rate; and those who cannot (who pay substantially lower fees, unless they have free access via medical cards).[41] Those who pay the market rate will enter the private system, where treatment is reasonably fast in most specialties, and surroundings vary from comfortable to luxurious. It can be quite different for those who enter the public system—even though they may occupy the same hospital building as private patients. Maev-Anne Wren, a researcher at Ireland's Economic and Social Research Institute (ESRI), and former government advisor,[42] describes it as follows:

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> ...in public hospitals, there are two forms of apartheid: two-tier access and two-tier care... The reality of two-tier access is not disputed. It exists, it is institutionalised, and it is getting worse. This is a system in which patients are treated according to income rather than need. Private care is delivered promptly and, generally, by consultants in person. Public patient care comes tardily and is generally delivered by doctors in training. Public patients may wait so long for care that they are effectively denied it. Death may intervene. When they are treated, their care may be of inferior quality to private patients.[43]

Waiting lists for those in public care can be very long. In February 2018, a neurology patient was given a hospital appointment date of January 2024, a wait of almost 6 years, for a first appointment.[44] While this is at the extreme end of waits, delays of two or three years are a normal part of the system. At the time of writing, there are approximately one million on waiting lists.[45] This is an extraordinary number for a national population of around 4.8 million. As mentioned, the Euro *Health Consumer Index 2017* stated that they are the longest waiting lists of 35 European countries surveyed. The *Index* notes that the administrative and delivery body for Irish healthcare, the Health Service Executive (HSE), intends to get waiting times down to a maximum of 18 months; if it does, they'll still be the worst in Europe.[46] (A caveat: it is difficult to make meaningful comparisons of waiting list data between countries, as there are no universal measurement criteria.[47]) If a person is injured or ill, long waiting times could be catastrophic. Orthopedic surgeon Jimmy Sheehan has noted: "It's an absolute national disgrace to have young children with scoliosis waiting any amount of time because the spine deteriorates very rapidly."[48]

The public system is not properly resourced; deliberately so, to encourage private medicine, and persuade the population to buy health insurance. Approximately 45 percent do at present[49] (the percentage fluctuates). Former minister for health, Brendan Howlin, (who had been minister in 1993/94 and is still active in politics) stated, in an interview: "I was content to feel that we could provide a first-class public health care system without realizing that if we did that there would be no reason for sustaining a private system. The government wanted a chunk of the population to pay for private health insurance but in order for that to happen, they really required the public system to be inferior. Why else, if it was first rate, would people pay for a private system?"[50] The same policies apply now. There is no compulsory health insurance; but fear-driven media coverage of the public system encourages people to buy it.

One place where the public and private systems converge is in hospital accident and emergency (A&E) departments. Private insurance, no matter how expensive, does not allow emergency cases to avoid them, with their frequent chaos and long waits on trolleys.[51] Having insurance does not guarantee access to private hospital care for those admitted via A&E. If a patient is assigned, on admission, to a doctor without a private hospital placement (and with a current vacancy), the patient will usually stay with that doctor in the public system, regardless of the level of their health insurance cover. Patients may still be charged private rates via their insurer (this happened to me).

The system is a European outlier. Broadly, European health systems can be classified into one of two categories, both of which offer near universal healthcare:

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Bismarck systems, in which eligible residents of a country are legally required to buy health insurance. Their premiums may be paid by their employer. Patients (customers) can normally choose their insurers, and there may be many to choose from. The insurers can be public or private organizations; the latter can be for-profit or nonprofit. Insurers and healthcare providers are usually independent of each other. Bismarck countries include Germany, the Netherlands, Belgium, and Japan.[52]
Beveridge systems, where healthcare is provided by the government, most treatment and drugs being free at point of entry, paid for from general taxation. Such countries include the UK, Spain, Italy, Nordic countries, and Cuba.[53,54]

Which system is better? People may have preferences, perhaps based on their ideology. Both systems are successful in Europe. However, the *Euro Health Consumer Index 2017* observes that the best performing countries on the index:

> ...consist of dedicated Bismarck countries, with the small-population and therefore more easily managed Beveridge systems of the Nordic countries squeezing in. Large Beveridge systems seem to have difficulties at attaining really excellent levels of customer value. The largest Beveridge countries, the United Kingdom, Spain and Italy, keep clinging together in the middle of the Index.[55]

Ireland belongs to neither category, as mentioned. Its public and private systems are deeply intertwined. 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. Also, private hospitals have been built on the grounds of public hospitals; sometimes by publicly paid doctors, using their publicly earned salaries, at least in part; and sometimes by business people without a medical background; or a combination of the two.[56] The subsidization of private health has reached a zenith with the *National Treatment Purchase Fund* (NTPF). This government fund pays for private care for patients who have spent too long on public waiting lists; it pays for them to receive private treatment either in Ireland or overseas.[57] This is useful for alleviating suffering, yet there is inefficiency in that the government pays private medicine to make up for the failings in the public system, instead of solving the problems in that system.

A mix of public and private healthcare is not unique to Ireland. For example, the United Kingdom and United States, polar opposites in how they organize their healthcare, and in their systems' underlying philosophies, have elements of both. Some people insure themselves privately in the UK, through its niche. The US has some socialized medicine; for example, the elderly, the poor and military veterans can receive subsidized or free coverage. In addition, some US private hospitals provide free care for those who need it. Ireland's system is unique, though, in its interdependence of private and public healthcare, to the detriment of the public system. In the words of an Oireachtas (joint houses of parliament) committee: "Private hospitals piggyback on cash-strapped state-funded institutions."[58] This piggybacking draws resources from the public sector into for-profit medicine, which the public sector can ill-afford. Tom O'Dowd, professor of general practice at Trinity College Dublin Medical School observed: "The private sector in medicine has a case to answer. With a few exceptions it does not invest in the university training of doctors

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nor is it, in most cases, capable of training future medical specialists... The public system drives our specialists... into a private sector that helps itself to their hard-won skills."[59]

In this complex system, Ireland's Department of Health has noted that "there is no framework which allows decisions to be taken in an integrated way that links systematically with the overarching principles of the Irish healthcare system and aligns resources with goals."[60] In spite of, or more likely because of, the inefficient system, Ireland spends more per capita on healthcare than countries such as the UK, Germany, Belgium, Denmark, Sweden, France, Spain, Japan and Australia.[61] (In 2017 €15 billion was allocated toward healthcare,[62] for a population of a little over 4.8 million.) Lack of spending is not the main issue; rather, it is the design and the fragmented nature of the system (including the government's subsidy of expensive private care), combined with inefficiency.

There have been attempts at improvement. For example, a 2014 White Paper, *The Path to Universal Healthcare*, proposed ending the two-tier system by means of universal health insurance;[63] it has not been implemented. In 2017 an Oireachtas committee, from all political parties, proposed a new pathway: *Sláintecare*[64] ('sláinte' meaning 'health' in the Irish language). It proposes, *inter alia*, "that clear entitlements to universal healthcare be provided to all, underpinned by legislation."[65] It also recommends improvement of the public system.[66] The current Taoiseach (Prime Minister) Leo Varadkar, who is a doctor, said: "Based on the all-party *Sláintecare* report, we will implement a ten year plan to modernise and streamline our health service. Because a country that spends the fifth highest in the world on healthcare deserves to have a top-tier health service."[67]

An implementation strategy was unveiled in August 2018.[68,69,70] However, Varadkar has stated that additional funds beyond the normal health budget will not be given to Sláintecare. The president of the Irish Medical Organisation (IMO) has criticized this: "we need... urgent and sustained investment to counteract the damage done by years of budget cuts and there is no detail on how or at what pace the Government plan to invest."[71,72] Responses to Sláintecare from professional bodies, unions and the media include: "the strategy lacks details... there are no costings... it is a shambles..."[73]

The healthcare system tends to be highly resistant to reform. There are various reasons for this, including the fact that the two-tier system has become a cultural norm that conservative governments are reluctant to interfere with significantly. Additionally, governments tend to view the world from a neoliberal point a view, as mentioned, with a market-oriented approach to problem solving, which entrenches the two-tier system. Also, vested interests have been frequently accused of impeding reform, to protect their own interests. Róisín Shortall, a TD (Member of Parliament/Teachta Dála) from the tiny Social Democrat party wrote:

> In order to get the health system we deserve, the government has to show its mettle and face down vested interests resisting these reforms, including the Irish Hospital Consultants Association, the insurance and pharmaceutical industries, and private hospitals.[74]

The two-tier system offers potential financial benefits to hospital consultants, offering the possibility for dual income from both sectors for those who wish to avail themselves of it. The government has suspected some consultants of working

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shorter hours than they are paid for in the public system, instead using that time to gain extra income from private patients. The government used private detectives to observe their working habits.[75] It is likely that attempts at reform will meet opposition from some doctors, and from some relevant business interests. There may also be opposition from many ordinary people, who value the escape route of private medicine; there may be reasonable fears that all healthcare could become like the public system if private healthcare is curtailed. There should be optimism about Sláintecare, but it must be cautious.

An Ethical Look at Ireland's Healthcare System

The Moral Foundations of the System

The system's problems are rooted in its ethical foundations. It is worth examining why it diverged so significantly from the European norm, by looking at the ethical views of those who won the argument against universal healthcare. There were two main opponents, as mentioned: the medical profession and the Catholic Church. The Department of Finance was also opposed, to a lesser degree.[76,77] It is useful to look at their reasoning in their own words, where possible.

First, the medical profession. The Irish Medical Association (IMA), which represented most doctors at the time, strongly lobbied against the mother and child scheme, objecting to "state controlled medicine."[78] A 1951 memorandum to government summed up their view:

> This Fabian technique... takes the form... of starvation of voluntary services and boosting of State services; of control of more and more of the profession by whole-time appointments and salaries; of State advertising of State services and denigration of the voluntary services; and finally of a conditioning of the people to accept the 'paternalism' of the State in all medical matters.
>
> ... [This] would lead to... lay control of medical services.[79]

The phrase 'Fabian technique' referred to the methodology of the Fabian Society in the UK; to introduce socialism very gradually, step by step, rather than by revolution.[80] The memorandum also warned of "the cancer of socialised medicine," and recommended that Britain's NHS should charge fees.[81] The ideological opposition to state involvement in medicine is clear. They also had practical objections: a possibility of clinical independence being subject to lay control and bureaucracy; and the replacement of self-employment with a salaried status, which had the potential for reduction in both income and social status. Rights of people to choose their doctors could be limited, and private GPs could be eliminated. Hospital consultants observed that the absence of a money relationship between doctor and patient would cause a deterioration in the quality of the health services.[82] The doctors also had an issue with treating the poor and the more well-off together: "dispensaries would repel the better off if they found themselves 'sitting beside tinkers' wives and others of a similar type.'"[83]

The Department of Finance objected on the grounds of cost; but also on the grounds that it would "amount in effect to the socialisation of medicine, and would entail an extension of benefit at the expense of individual liberty."[84]

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The most powerful opponent was the Catholic Church; at the time, Ireland was an extremely religious country. Essentially, the Church ran most of the nation's healthcare system. It owned most hospitals; most hospital doctors worked for Church institutions, and most were Catholic. The Church and medical profession were in a symbiotic relationship, mutually dependent regarding healthcare provision. Some historians suggest that it was the medical profession that persuaded the Church to join the fight with it against socialized medicine; a bishop later reflected that they "allowed themselves to be used by the doctors."[85]

In any case, the Church's views on the mother and child scheme were stated in a letter from the bishop of the diocese of Ferns, representing all the bishops, to the Taoiseach:

> ...for the state, under the Act, to empower the public authority to provide for the health of all children, and to treat their ailments, and to educate women in regard to health, and to provide them with gynaecological services, was directly and entirely contrary to Catholic social teaching, the rights of the family, the rights of the Church in education, and the rights of the medical profession, and of voluntary institutions.[86]

These seem harsh and shocking words. They must be read in the context, though, that the Church ran hospitals and other health facilities on a huge scale, in Ireland and overseas. Their issue was not that providing for the health of children, education of women, etc., was undesirable. They provided these things themselves; they just did not want the state to do it. The main opponent of the scheme, Archbishop John Charles McQuaid of the Dublin archdiocese, founded organizations to help the poor and helped to establish a major children's hospital.[87] The bishops also observed that the scheme was "motivated by a sincere desire to improve public health...[but was] in direct opposition to the rights of the family and the individual... [and] a readymade instrument for future totalitarian aggression."[88]

Some of the bishops' statements resist a charitable interpretation. For example: "it was unfair to tax the rest of the community in order to give the poor a free health service";[89] also, the state should not "deprive 90 per cent of parents of their rights because of 10 per cent necessitous or negligent parents" (the percentage of the poor was actually over 30 percent.)[90] They also argued that the state "should not undermine a father's obligation to support his family;"[91] and that free healthcare would damage "the sense of personal responsibility and seriously weaken the moral fibre of the people."[92] These points were made in the context that unemployment, poverty and forced emigration were high in the fledgling state, and there were high infant mortality and maternal death rates.[93] Many families could not pay for healthcare, or struggled greatly to pay. Such statements reveal a lack of regard for society's poorer members. The bishops also noted that "education in regard to motherhood includes instructions in regard to sex relations, chastity and marriage. The State has no competence to give instruction in such matters."[94] They additionally asserted that the scheme could be a slippery slope that would lead to abortion, contraception, euthanasia and sterilization.[95] Also, Archbishop McQuaid wished to save "the country from advancing a long way towards socialistic welfare."[96]

The Minister for Health, Noël Browne (a doctor, Catholic and socialist), who became the campaigning champion of the scheme in the face of great opposition wrote, in his autobiography, about how he lobbied the bishops, unsuccessfully.[97,98]

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He described a conversation with Ireland's chief bishop, Cardinal D'Alton of Armagh (the headquarters of the Irish Church); a diocese which straddles the border between the Republic of Ireland and the North (as do three others).[99] Britain's NHS was up and running in Northern Ireland at this stage. Browne asked D'Alton why Catholic bishops there had no objection to Catholics using the NHS; to which D'Alton responded: "we are prepared neither to apologise, nor to explain."[100] Browne claimed that the instinct of the bishops was to support wealthy hospital consultants,[101] whose income could be affected by a national health service.

The Church fought hard against the mother and child scheme. The Dominican Order issued a pamphlet which explained the scheme in a question and answer format (mirroring the structure of the Catholic Catechism taught to children at the time). Browne gave extracts:

> Question: Is it a mortal sin to introduce a mother and child health service?
>
> Answer: It is a sin to introduce a mother and child no-means-test service.

(A mortal sin, in Catholic tradition, is a sin that merits eternal damnation in hell unless it is repented of.)

> Question: Is it true that the communist party believes in free health services?
>
> Answer: It is true that the Communist Party has a free health service.[102]

The strength of the bishops' views can be illustrated by two quotes. Bishop Michael Browne of Galway said that the education of children by the state:

> ...was based on the Socialistic principle that children belonged to the State... and reminded one of the claims put forward by Hitler and Stalin. Surely the world had learned so much of the horrors of such claims that any country which respected Christian rights and liberties should be anxious not to give the State such dangerous powers.[103]

The Coadjutor Bishop of Cork, Cornelius Lucey, stated:

> The Welfare State is almost upon us. Now, under one pretext, now under another, the various departments of State are becoming father and mother to us all. Now it is on Socialist reasoning thinly disguised – because mothers and children are the hope of the future and so of the nation and the State, because all in the land are equal and should receive the same treatment, etc; now it is on humanitarian grounds – because parents cannot afford to look after their children as well as the State can, or cannot be expected to know how to look after them as well as the department experts can, and hence the constant reference to bad or reckless parents...[104]

There are legitimate concerns about the intrusion of the state into people's lives. Nevertheless, it would appear that almost any humanitarian ideals could seem suspect to these bishops; akin to a communist plot.

In addition to Catholic opposition, there was opposition from the largest Protestant Church, the Church of Ireland (Anglican); an editorial in the *Church of*

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Ireland Gazette said that the mother and child scheme was a "communist interference in the family."[105] Ultimately, a 'reds under the bed' mentality, which existed among many conservatives at the time, may have been the root of much Christian fear of socialized medicine. (In the US, this was the McCarthy era.)

To be blunt, many of those arguments that won the day seem iniquitous.[106] Some, though, raise genuine questions. There must be valid concerns when a change as large as socialized medicine is proposed. Could bureaucrats override doctors' professional autonomy? Could medicine be subject to political whims, ever changing? Could an all-encroaching state reduce personal liberty? There was genuine and justified disquiet about communism. Yet across Europe and elsewhere, national health systems were designed in which such concerns were not significant factors.

It took a fourth group to deliver the *coup de grace*; Ireland's political leaders. Initially the scheme had widespread political support. But when the Church hierarchy intervened, most politicians dropped their support; in Browne's own words, "it became the Dr. Noël Browne mother and child scheme."[107] Each cabinet member professed his loyalty to the bishops at that point, with statements such as: "as a Catholic I obey my authorities"; "those in the government who are Catholics are bound to accept the views of their Church"; and "who would oppose the positive teaching of those entitled to teach?"[108] Taoiseach John A. Costello reflected the national mood when he told the Dáil: "I am an Irishman second, I am a Catholic first, and I accept, without qualification, in all respects, the teaching of the hierarchy and the Church to which I belong."[109] Costello also displayed *realpolitik*, saying: "whatever about the doctors, I am not going to fight the Bishops, and whatever about fighting the Bishops, I am not going to fight the doctors and the Bishops."[110] As for Browne; he ended up defending the scheme, largely alone. This ultimately led to his resignation and the end of his career as a senior politician. But in his defeat, he said: "the Hierarchy has informed the Government that they must regard the mother and child scheme proposed by me as opposed to Catholic social teaching. This decision I, as a Catholic, immediately accepted without hesitation."[111]

It is clear that the Church had great power in Ireland at the time; the word of its hierarchy was, in essence, holy writ. Which raises a question: could Irish doctors and the Department of Finance have defeated the mother and child scheme, and the national health service that was meant to follow, without its support? The Irish medical profession was not alone in opposing universal healthcare; for example, in the UK, there was significant and challenging opposition from doctors to the founding of the NHS.[112,113] Doctors in the US and Canada also fought it.[114] They lost the fight in the UK and Canada; they won in the US.[115]

It seems certain that the Irish doctors would have lost their battle without the Church's support. Ireland was located in a Europe where national healthcare systems were being introduced throughout; they were part of the *zeitgeist*. Added to that, the cultural influence of Ireland's former colonial ruler, so much larger and geographically so close, was strong, and there was frequent travel between the two, as well as frequent moving back and forth for work (mostly from Ireland to the U.K.); a flourishing NHS would be well known in Ireland. Given that the major Dáil parties had initially supported the mother and child scheme and the universal healthcare that was to follow, and given the respect and deference given to the Church by most Irish people at the time, it seems impossible that the medical profession would have prevailed had the Church taken the other side; indeed, they would almost certainly have deferred to the bishops themselves, mirroring

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the deference of the Cabinet. Even if the Church had remained neutral, it seems likely that the medical profession would have been defeated in these circumstances, as were their colleagues in the UK and Canada.

This view is supported by the fact that after a general election, a new government introduced a truncated version of the scheme in 1952, designed with the hope of achieving Church and medical support. It allowed for free healthcare for mothers and children under a certain income threshold, rather than for all; and it reduced the age for children's entitlement from 16 years to 6 weeks. It also abolished the state's involvement in the education of mothers. Even this truncated scheme was initially opposed by doctors and the Church. One Church argument against it was that "patients may be treated by people with pernicious Freudian and materialistic principles."[116] Yet after obtaining concessions, the Church abandoned its opposition. Without the Church's support, the doctors also abandoned theirs.[117]

In the words of surgeon Liam Kirwan, who wrote a polemical history of the events: "It is clear that the hierarchy, in striving to prevent this benevolent measure, were straying far from the path of Jesus Christ, and the doctors... from that of Hippocrates. Indeed, it is tempting to offer that it would have caused the former, if He had not risen from it on the third day, to turn in his grave."[118] The Church's rejection of central aspects of its own ethos, combined with the doctors' opposition to a central aspect of their own healing vocation, are at the root of today's underperforming and dysfunctional healthcare system.

Nevertheless, these events occurred in the 1950s. There has been plenty of time to change the system, but it remains dysfunctional. In the decades that followed, the Church became more liberal; by the 1970s and 80s, it became an advocate for a more just health system.[119] But it was losing influence at that point; politicians and the population at large were no longer subservient to its views, even though religious practice remained high. A 2012 document from the Irish Bishops' Conference approved the idea of "a single-tier health service which guarantees access to medical care based on need, not income, and a funding system based on the principle of social solidarity."[120] It received little publicity, for the Church had largely fallen from grace in Irish society at that point. Ironically, the Church is no longer able to run the health system, due to lack of personnel (though it maintains significant ownership of medical institutions). It rarely speaks on social issues now, and when it does its voice is little heard. The main political parties have moved to the right, tending to be fiscally conservative, though frequently socially liberal.

What is an Ethical Healthcare System?

What ethical principles should guide the design and implementation of a healthcare system? That could be debated at length; but a definition by Health Consumer Powerhouse seems to encapsulate the main points: It suggests "a health care system that suits every citizen and where everyone has equal access to the best standard medical care."[121] This seems like a reasonable starting point.

To put it another way, John Rawls' *veil of ignorance* could be invoked; a health system where those who design it do not know what their position in society will be; healthy or sick, rich or poor... Rawls' theory suggests that they would then design health systems which elevate the common good, where even those on the very bottom will have an acceptable standard of care.[122]

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This can be compared with a statement of orthopedic surgeon and medical entrepreneur, Jimmy Sheehan; a surgeon and pioneer of private medicine who founded three of the country's leading private hospitals, the Blackrock Clinic, the Galway Clinic and The Hermitage. He said: "The state cannot provide for everyone. That is what they tried to do in the communist states and they failed miserably. I think health is a bit like housing. People are entitled to different levels of housing. If they want to put their effort into providing for better housing, they have to work very hard for it and people have forgotten about that in relation to their own health."[123]

Although proponents of public vs private healthcare frequently see their own position as the only ethically correct one or, at least, the best ethical solution, the issues are complex. How a system is run is also a central issue for patient care. Take Jimmy Sheehan's quote; it suggests a freewheeling capitalist approach to healthcare, yet does not completely sum up his views. His work in establishing private medicine appears to come from his experiences of inefficiencies in the public system; for example, of having his working hours cut while many patients were on waiting lists, leaving orthopedic patients to deteriorate. He wanted to provide an alternative.[124]

Many proponents of private medicine argue that an entirely public system could reduce all healthcare to the inefficiency of the public system, without the escape route of private care. An example can testify to the truth of this: an emergency operation for a woman in Northern Ireland, who suffered a detached retina, was postponed by the NHS at the last minute, to allow a person with the same problem, and just one eye, to get the same operation. This postponement meant that this woman would almost certainly lose her eye. She was told: "the woman we're treating has only one eye, so if you lose one at least you still have one left."[125] She attempted to get private care in Northern Ireland, but was unable to arrange it. So she paid for a private operation in the Republic of Ireland.[126] This is an example of how a well-developed private system can avert negative, even tragic, outcomes from an inefficient public health system. But that only works if the patient can pay. Also, the NHS has been declining in recent times, due, at least in part, to financial cutbacks.[127] It could be improved.

The broader issue of political management of the country, and political culture, is highly relevant to the state of the health system. For it is not the only dysfunctional area in Irish life. There have been scandals in many areas, including political, business, police and Church corruption, and the recent development of large-scale homelessness. Even a current attempt to build a new National Childrens' Hospital has resulted in great controversy; due to a huge overrun in costs, it is now estimated that it will cost more than world landmark buildings such as the Shard, the Burj Khalifa, the Petronas Towers and Wembley Stadium. Also, the country's infrastructure is relatively undeveloped. The health system's crisis exists in the context of many crises.[128,129] Thus, even if universal healthcare had been established, it seems likely that it may be inferior to European norms. Nevertheless, the system's design makes it even less fit for purpose.

Neoliberal ideology is an issue. As mentioned, the public system is under resourced, in order to 'encourage' as many people as can afford it into private healthcare. During the recession, huge cutbacks were made to the already depleted

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public health system, including reductions in the salaries of doctors and nurses. This was justified on the basis that the government lacked money. Yet the government bailed out banks, Irish and foreign, to the tune of tens of billions of euros. In this it was largely obeying orders of the Troika (the European Commission, International Monetary Fund (IMF) and European Central Bank). However the government is defying the European Commission over the issue of preferential tax treatment for Apple. Apple was given tax breaks over many years, worth €13 billion (meaning they paid an effective tax rate of 0.005 percent on their profits in Europe in 2014). The Commission found this to be illegal, and ordered Apple to pay back the money.[130] Ireland has been reluctant to take it, so is facing a lawsuit, from the Commission, in the European Court of Justice.[131] Also, as mentioned, the private healthcare system, which is becoming increasingly corporatized, and in which foreign companies are establishing a significant presence, is subsidized by government. Clearly ideology is an important factor in the state of the health system.[132]

Does the health system simply reflect the moral values of Irish society? Perhaps, at a fundamental level, in spite of the criticisms of many. It is a fact that the Irish keep voting for fiscally conservative politicians, mostly, and no significant left wing movement has developed. Any reforms will develop within this paradigm. In this political context, a health service that meets the HCP's definition, or the test of Rawls' veil, seems unlikely to happen.

Abortion, Savita and the Irish Healthcare System

A constitutional prohibition on abortion was recently removed in Ireland. Abortion's legalization occurred in a unique manner; not as a result of considered academic, judicial, parliamentary, societal... etc. debate, but primarily as a response to dysfunction in the health service, combined with the existence of restrictive abortion laws, which led to the death of a pregnant woman in 2012—an Indian dentist who lived in Ireland, Savita Halappanavar.[133] The circumstances of her death caused a national outpouring of grief and anger, almost comparable to the reactions to the death of Princess Diana in the UK.

To set the context: Until May 2018, Ireland's Constitution prohibited abortion, except in very limited circumstances. Ireland has a written Constitution, and laws cannot be created that are "in any respect repugnant" to it (Article 15.4.1°); any such laws are "invalid" (Article 15.4.2°)[134] and can be challenged and struck down in the courts. A referendum was held in May 2018 in which the Irish people voted on whether the constitutional ban on abortion should be removed. The government said it would grant abortion on demand up to 12 weeks, and with restrictions after that, if the referendum passed.[135] Legalization of abortion was supported overwhelmingly: 66.4 percent in favor.[136]As a result, the following has been inserted into the Constitution:

> Article 40.3.3°: Provision may be made by law for the regulation of termination of pregnancy.[137]

Ireland was one of the last countries in Europe to legalize abortion; only in Malta does it now remain illegal.[138] Generally, abortion has been introduced around the world by lawmakers. In Ireland, it has been introduced by popular vote. The government legislated for abortion in the Health (Regulation of Termination of Pregnancy) Act 2018, which came into force on January 1st 2019.[139]

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To further explain the context: Ireland's Constitution (implemented in 1937) can be amended by popular referendum (as per Articles 46 and 47).[140,141] In 1983, a referendum was held for an 8th Amendment to the Constitution to input an article that gave equal rights to the life of a mother and her unborn child. Abortion was illegal at the time, but it was possible that this could be changed by the legislature or judiciary. Amending the Constitution would definitively prevent such change. The text to be inserted, Article 40.3.3°, read:

> The State acknowledges the right to life of the unborn and, with due regard to the right of the mother, guarantees its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.[142]

The Irish people passed the referendum, 66.9 percent being in favor. Three later referenda were held, which fine-tuned Article 40.3.3°; after which it read:

> The State acknowledges the right to life of the unborn and, with due regard to the right of the mother, guarantees its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.
>
> This subsection shall not limit freedom to travel between the State and another state.
>
> This subsection shall not limit freedom to obtain or make available in the State, subject to such limitations as may be laid down by law, information relating to services lawfully available in another state.[143]

In 1993, the Irish government secured Article 40.3.3° into EU law that is applicable to Ireland, negotiating the following protocol in the Maastricht Treaty:

> Nothing in the Treaties, or in the Treaty establishing the European Atomic Energy Community, or in the Treaties or Acts modifying or supplementing those Treaties, shall affect the application in Ireland of Article 40.3.3° of the Constitution of Ireland.[144]

Following Savita's death (I refer to her by her first name, as Irish political, media and public discourse always do so), the abortion laws were somewhat liberalized in the *Protection of Life During Pregnancy Act 2013*. It allowed for abortion in situations when the mother's life or health was in danger. This had to be certified by at least two doctors, relevant specialists (except in case of emergency, where one could both certify necessity and perform an abortion).[145] Abortion remained a crime outside of these situations, with a possible prison sentence of 14 years.[146]

There have been ongoing pro-abortion campaigns over the years, which failed. Two events changed this, and gave strong impetus to a campaign to legalize abortion; the primary event being the death of Savita, and a second event being a constitutional referendum which approved gay marriage in 2015. The latter was important in that it showed that radical change was possible; Ireland is the only country in the world to approve gay marriage by a popular vote. But the death of Savita became the foundation of a cause to repeal the constitutional prohibition on abortion. A campaign, *Repeal the Eighth*, arose, with that slogan appearing on (usually beautiful) posters and graffiti around the country.

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The popular narrative on Savita's death is as roughly follows. She was admitted to Galway University Hospital to give birth, as a public patient. She became ill, developed sepsis, and her fetus was certain to miscarry. In her pain, she asked for an abortion; she thought it would save her life, and her fetus was due to miscarry anyway. She was refused; she died, as did the fetus. In the narrative, she would have lived if she had been granted the abortion. Her family—parents and husband—mounted a campaign, highlighting the injustice of her case. There was a strong media response, which largely used the case to campaign for abortion, even before the facts of her death were known (one dissenting journalist described this campaign as "an ideological holy war").[147] Marches took place; one in Dublin had tens of thousands of people. People sat on streets in groups, with candles, sitting around photos of Savita. Pro abortion campaigners were granted the public spotlight like never before.[148]

Three investigations into her death took place; a coroner's inquest, a study by the HSE, and a study by the Health Information and Quality Authority (HIQA)—which supervises the health system, including the HSE. Investigators concluded that the symptoms that caused her death were sepsis, combined with a strong antibiotic-resistant e-coli infection, and inflammation of the fetal membrane, the latter being associated with her miscarriage.[149] These were combined with multiple instances of medical neglect; she was not properly monitored, and medical staff did not respond appropriately to her symptoms.

The inquest concluded that her death was caused by medical misadventure. As for the HSE's report, a statement from the chairman of the group that authored it appears, initially, to support the popular narrative. Professor Sir Sabaratnam Arulkumaran, former president of the UK's British Medical Association, the Royal College of Obstetricians and Gynaecologists, and the International Federation of Gynaecology and Obstetrics,[150,151] said: "She did have sepsis. However, if she had a termination in the first days as requested, she would not have had sepsis. If she had the termination when asked for it, the sepsis would not arise. We would never have heard of her and she would be alive today."[152] Be that as it may, the HSE's 108-page report concludes that her death was caused by the poor treatment she received after contracting sepsis. Whatever the reasons for her contracting sepsis, had her treatment reached normal professional standards, she may have lived.[153] Its summary, in a press release, states the causes of her death:

1. Inadequate assessment and monitoring of Ms. Halappanavar that would have enabled the clinical team in UHG [University Hospital Galway] to recognise and respond to the signs that her condition was deteriorating. Ms. Halappanavar's deteriorating condition was due to infection associated with a failure to devise and follow a plan of care for her that was satisfactorily cognisant of the facts that:

   - the most likely cause of her inevitable miscarriage was infection and
   - the risk of infection and sepsis increased with time following admission and especially following the spontaneous rupture of her membranes.

2. Failure to offer all management options to Ms. Halappanavar who was experiencing inevitable miscarriage of an early second trimester pregnancy where the risk to her was increasing with time from the time that her membranes had ruptured.

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3. UHG's non-adherence to clinical guidelines relating to the prompt and effective management of sepsis, severe sepsis and septic shock from when it was first diagnosed.[154]

The press release noted: "The HSE and University Hospital Galway apologises unreservedly to Mr. Halappanavar for the tragic and untimely death of his wife at University Hospital Galway on 28th October 2012."[155] The HIQA report (running to 257 pages)[156,157,158] reached similar conclusions; its press release noted that "The investigation findings reflect a failure in the provision of the most basic elements of patient care to Savita Halappanavar."[159]

The fact that Savita was grossly neglected, and her medical care did not meet professional standards, caused her death, according to those who investigated it. But if the fetus had been terminated early, the illness that led to the neglect would not have arisen. The eighth amendment did not prohibit such terminations to save the mother's life.

The question arises as to whether Savita's status as a public patient was a factor in this. That cannot be answered definitively; excellent care can take place in the public system, and it can be suboptimal in the private sector. Nonetheless, private healthcare is far superior to public, generally, which is why so many pay for it. The HIQA report identified—among other issues—13 "missed opportunities to intervene in [her] care pathway...over the course of the four days before she died." Any of these interventions could, possibly, have saved her life.[160] There were numerous other mistakes.[161] It seems plausible, though not guaranteed, that the outcome may have been different if Savita had been a private patient; that she may be alive now.

It is this tragedy that led to Ireland's constitutional prohibition on abortion being overturned.[162] Would that have happened anyway? Possibly, with changing social mores; but it is difficult to be certain. It seems likely that if it did, it would have taken much more time. For many in the majority that voted for repeal of the eighth, there is an awareness that their success is born from tragedy, caused by a death which resulted from a poorly functioning health system. (Many of the pro-choice election posters around the country had photos of Savita, and her death was constantly brought up by the pro-choice side in media debates. Shortly before the referendum, a mural of her was painted in Dublin; it became a shrine, drawing a constant stream of solemn visitors; lighting candles, and leaving messages and flowers.[163]) For many in the minority who see abortion as a moral disaster, there is that same awareness, that the poor health system is a major cause of abortion being introduced into Ireland.

Savita's heartbreaking case has gathered world-wide coverage; most of it, at home and abroad, focused on the abortion issue. But at its heart, her tragedy seems to have been caused, primarily, by the defects in the Irish healthcare system. Savita's death was headline news; but many more people quietly die, or are left disabled or ill, because of flaws in the design and implementation of the health system. Her death is a pointer to much hidden suffering.

Finally, it has been noted that the rapid introduction of abortion to the dysfunctional health system, with little preparation, is likely to put further pressure on that system; for example:

> women suffering from damage to their bladders after childbirth, pelvic organ prolapse, faecal incontinence, crippling endometriosis or incomplete miscarriages will have to compete for beds with women opting to have… abortions.[164]

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Also, the legislation does not permit full freedom of conscience for medical professionals who oppose abortion. This could lead to workplace conflict, and a possible exodus from health professions.[165]

Conclusion

Ireland's healthcare system is a morality tale brought to life. Ethically, it is a debacle to a large degree, even though high quality healthcare can still exist within a suboptimal, at times chaotic, system.

The root of this debacle is the defeat of the mother and child scheme and the universal health service that was to follow, which meant that Ireland's health system fell behind its European peers. Although the Catholic Church was the main provider of health care, it blocked the government from moving to the next level; from advancing with many other European countries to a healthcare service that gave equal treatment to all, regardless of their financial status; one that recognized the inherent dignity of every human being. It is disheartening to observe that a supposedly spiritually oriented group, which regarded itself as a manifestation of God's kingdom on Earth, forced the rejection of a healthcare system that would have offered high quality healthcare to all people. Instead of a spirituality which mirrored Christ's healing ministry, they manifested a virulent conservatism which resulted in the best care being restricted to those who could afford it. It could have been so different. One could question their attitudes, deeply. Were Christ's healing gifts granted only to those who could pay?

As for the medical profession: although they were less powerful than the Church, they used the significant power they had (including influencing the Church) to maintain a suboptimal system, instead of allowing a state-of-the-art health infrastructure to flourish that could greatly benefit their patients. Issues of ideology and of pay and status seemed to be of greater importance to them than the common good.

The system's problems are rooted in flawed religious and professional ethics; these disabled the system at a time when it had a chance to prosper. The arguments that won the day must have rung hollow for those who could not afford good medical care; particularly for the bereaved, or those who became disabled or remained ill due to lack of ability to pay. The winning "moral" arguments had negative real world consequences for many people. The system's flawed ethical foundations have never been properly addressed in practical ways; and have been added to subsequently by defective political thinking, the influence of vested interests, and human failure.

The defects in the health system's design are predicated on a failure in morality. In the words of Gandhi: "good results will never be achieved by immoral means."[166] Only a change in ethical outlook, manifested through a change in political outlook, can reestablish the health system. As the Church was the most powerful opponent of universal healthcare, its opposition can be regarded as the original sin at the root of today's problems. The views of another, very different Catholic leader, Pope Francis, could be a useful foundation for renewal: "Health is not a consumer good but a universal right, so access to health services cannot be a privilege."[167,168]

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a patient pays €80 per day, up to a maximum of €800 in any year. There is another primary care point of contact; private clinics, run by insurance companies or other business groups, which have appeared on the scene in the last decade or so. Their fees are slightly higher than public hospital consultations; and they allow the queues of public hospitals to be avoided, but only treat relatively uncomplicated issues.

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