

**Ireland as Catholic corporatist state: a historical
institutional analysis of healthcare in Ireland**

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INTRODUCTION

In order to examine developments in the organization and administration of the welfare state, where institutions refer not only to political structures and organisations but also to decision-making patterns and more broadly based views of state development, we require some means of conceptualising the state that is flexible enough to encompass these features yet at the same time concrete enough to give some kind of analytical clarity. This study uses the regime templates provided by Esping-Andersen's (1990) characterisation of contemporary welfare states in order to classify the Irish state and chart its evolution.

Although the location of the Irish case was of no great significance to Esping-Andersen's (1990) work, his classification of Ireland within the 'corporatist-statist' category did exercise a few (Ragin, 1994; McLaughlin, 1993; Peillon, 2001). This is of interest to us for a number of reasons. As with other comparative studies, some authors have sought to present Ireland as a unique case - one that cannot be accommodated within Andersen's typology (Ragin, 1994; Peillon, 2001). We are keen to demonstrate that the Irish state can and should be viewed in a comparative context. Moreover, we believe that the persistent presentation of 'Ireland as the counterfactual' in comparative work is damaging to Irish policy studies and analysis.

We have chosen healthcare for analysis not only because of its central importance to studies of the welfare state, but also since health policy is in many ways a key indicator for other welfare issues. The health of the population is not just about a good health service but dependent on a myriad of factors such as housing, sanitation, working conditions, environmental pollution, education, unemployment and the general economic conditions of the country (Millar, 2004). As a consequence, health policy spans many areas, not least of which are hospitals, direct healthcare services and health promotion.

In order to develop our analysis, the first section of the paper looks at Esping-Andersen's (1990) classification of welfare regimes and the rationale for classifying Ireland within this group. The second section outlines the three major variables that Esping-Andersen suggests contribute to alternative regime types. These are: the pattern of working class formation; political coalition building in the transition from a rural economy to a middle class society; and evidence that past reforms have contributed decisively to the institutionalisation of class preferences and political behaviour. This section of the paper explores each of these themes in detail in relation to the Irish case. In the third section, we assess to what extent the distinguishing features, marked out by Esping-Andersen as being characteristic of the corporatist-statist model, are evident in the case of Irish healthcare. Using a historical institutionalist approach, we argue that the evolution of Irish healthcare has been marked by a series of critical legislative junctures that mark out defining moments in the system's progress. These are: the establishment of the Dispensary System in 1851; the Health Insurance Act 1911; the Mother and Child Scheme 1947; the Health Act of 1953 and the Health Act of 1970. Our central argument is that the core values identified in Anderson's corporatist-statist model and evidenced in the Irish case, inevitably paved the way to the contemporary healthcare set-up in Ireland. In other words, the Catholic Corporatist values that predominated in the post-independence period effectively precluded the state from introducing a comprehensive healthcare service along the lines of those being introduced in most other European states.

ESPING-ANDERSON'S 'THREE WORLDS OF WELFARE' AND THE IRISH CASE

Anderson (1990: 26-29) argued that welfare states vary considerably with respect to their principles of rights and stratification. This results in qualitatively different arrangements among state, market and family. These differences notwithstanding, Anderson argued that welfare state variations are not singular, but clustered around three central regime types: 'liberal'; 'social democratic'; and 'corporatist-statist'; the so-called 'three worlds of welfare'.

'Liberal' welfare states are characterised by means-tested assistance, modest universal transfers, or modest social insurance. This form of welfare state mainly caters for low-income, usually working-class, state dependants. It is a model in which, implicitly or explicitly, the progress of social reform has been severely constrained or circumscribed by traditional, liberal work-ethic norms. Entitlement rules are strict and often associated with stigma. Benefits are typically modest. In turn the state encourages the market, either passively by guaranteeing only a minimum, or actively by subsidising private welfare schemes. Archetypal examples of this model are the US, Canada and Australia.

'Social Democratic' welfare states by contrast comprise those countries where welfare provision is extended to all – including the middle classes – as a matter of entitlement. Most usually associated with the countries of Scandinavia, this group is the smallest taking its name from the so-called "social democratic" model of government that has prevailed in Nordic states since the 1930s. Rather than tolerating a dualism between those catered for by the market, and those by the state (the middle and working classes), Social Democratic governments in the Nordic states pursued a welfare state organisation which would promote and *equality of the highest standards*, as opposed to the provision of minimal needs elsewhere. Under this system, manual workers could enjoy the same social rights as those of the salaried middle classes. All strata of society are incorporated under one universal insurance system, though benefits are graduated according to accustomed earnings. This model essentially replaces market provision and so engenders a universalistic solidarity behind the welfare state. All benefit, all are dependent on it and so, presumably, all feel obliged to pay/support it.

In this study, we are concerned with the application and adaptation of Anderson's 'corporatist-statist' type to the Irish case. This group, composed of states such as Austria, France, Germany and Italy, comprises those states with historical corporatist tendencies, which were subsequently "upgraded" in the post-war period. In these states, the liberal obsession with markets and market efficiency as a means of providing goods is not as prevalent as in other more liberal regimes but the maintenance of status differentials, so that social rights are strongly attached to class and status is an important feature. Corporatist regimes are also typically shaped by the Church, and hence strongly committed to the preservation of traditional family hood. Social insurance typically excludes 'non-working' wives and family benefits encourage motherhood. Day care and similar family services are conspicuously underdeveloped and the principle of 'subsidiarity' underscores the fact that the state will only interfere when the family's capacity to service its members is exhausted. The consequence for corporatist regimes was that hierarchical status-distinctive social insurance cemented middle class loyalty to a peculiar type of welfare state.

Applying the Corporatist-statist model to Ireland

With the odd exception (Lalor, 1982), few academics have gone so far as to suggest that post-independence Ireland could be regarded as genuinely corporatist and the extent to which the corporatist framework fits at all has been subject to debate (Hardiman and Lalor, 1984, Roche and Cradden, 2003). Certainly, however, throughout the 1950s and early 1960s, the establishment of a number of consultative and advisory bodies comprising employer, trade union and government representation (such as the Capital Investment Advisory Committee, the Committee on Industrial Organisation, the National Industrial and Economic Council, and its successor, the National Economic and Social Council), suggested that although the Irish state could not be regarded as completely corporatist, it was certainly ‘corporatist leaning’ (Hardiman, 1992; Murphy and Roche, 1994; Cradden, 1999). During the 1930s, both *Fine Gael* and *Fianna Fáil* showed an interest in the principles of vocationalism: the former through its inclusion of the ‘Blue Shirts’ into its parliamentary precursor, *Cumann na nGaedheal*; and the latter through the incorporation of vocationalist principles into the 1937 Constitution drafted by De Valera. Despite these early tendencies, however, the trend was not to last. Thus, for example, although the majority of members of the second chamber of the *Oireachtas*, the *Seanad*, are elected from five ‘vocational’ panels of candidates representing the main interests in Irish public policy (Cultural and Educational, Agricultural, Labour, Industrial and Commercial, and Administrative),¹ the significance of party politics soon outweighed the significance of any collective interest within the panels.

If anywhere, the corporatist tendency was strongest in the management of the economy. The creation of the Labour Court, in 1945, was intended to regulate wage levels and ‘in a very short time, intensive, concentrated, periodic negotiations between employers and unions became the norm, and the phenomenon of pay rounds had arrived’ (Cradden, 1999:52). As it turned out, the Labour Court failed to live up to its corporatist birthright and soon turned into an independent state arbitration service; and right up to the 1970s, the government input into wage rounds (*vis-a-vis* that of business and trade unions) was probably the least significant of all. Still, the *National Understandings* of 1979 and 1980 marked a subtle shift in the nature of Irish decision-making.² ‘They began the integration of management and trade unions into the formulation of public policy’ (Lee, 1979:20) so that throughout this period, the ‘drift towards *neo*-corporatism’ was increasingly evident (Roche, 1994; Roche and Cradden, 2003).

There followed a string of national concordats between agreed ‘Social Partners’, sufficient to suggest that *neo*-corporatist frameworks are of considerable utility not only in accounting for specific developments in Irish industrial relations, but also for changes in the process of economic governance more generally (Roche and Cradden, 2003:83). In 1987, the negotiation by government of the *Programme for National Recovery (PNR)* - a three year deal covering pay agreements, tax concessions, productivity deals and commitment to increased employment, signaled the advent of ‘partnership government’ in Ireland. After the *PNR*, came the

¹ The *Seanad* has 60 members: 43 are elected from five panels of candidates; 11 are nominated by the *Taoiseach*; and the remaining 6 are elected by a selection of universities (three by the National University of Ireland and three by the University of Dublin).

² Both National Wages Agreements were negotiated directly between the government, the Irish Congress of Trades Unions, & employer organizations (Chubb, 1992:125-30; Lee, 1989:537-40)

Programme for Economic and Social Progress (PESP) covering the period up to 1993. *PESP* was followed by the *Programme for Competitiveness and Work (PCW)*, running until 1996. A change of government led to a change of emphasis in the next concordat, *Partnership 2000* (- the year designated for its expiration), which in addition to pay and tax deals also included an explicit endorsement of ‘developing partnership in the workplace’ as a means of improving international competitiveness. Essentially, however, the same format was applied. The successful negotiation of the most recent *Programme for Prosperity and Fairness (PPF)*, due to run until 2004, would suggest that ‘government by partnership’ is now the norm in Ireland. Though debate still exists as to whether this forms a renewed version of classical corporatism, or a new form of *neo* or *post* corporatism (see: Roche and Cradden, 2003 and O’Donnell and O’Riordan, 2000 respectively), it is clear that the corporatist paradigm - in one guise or another - is still the most engaging for academics studying the Irish case. More pertinently, for the purposes of this analysis, it shows that Ireland may be included amongst those states with historical corporatist tendencies (even if they are not evident to the same degree as other more enthusiastic European counterparts) and thus warrants inclusion in Esping-Andersen’s corporatist regime cluster.

If the evidence for Irish corporatism is weak compared to other European exponents of the system, the evidence for Roman Catholic hegemony is persuasive. The integration of Church and state in post-independence Ireland was such that the teachings of the Catholic Church governed most aspects of state policy, including social policy (McLaughlin, 1993). The proposition that ‘corporatist regimes are also typically shaped by the Church, and hence strongly committed to the preservation of traditional familyhood’ (Esping-Andersen, 1990:27) is borne out by early state attitudes to the position of women and family in Ireland. Many state benefits *did* exclude ‘non-working’ wives and ‘non-deserving’ women and clearly social policy was designed to perpetuate a ‘vision of the role of woman in Irish society as a full-time wife and mother in an indissoluble marriage, having a preference for ‘home duties’ and ‘natural duties’ as a mother (Scannell, 1988:125). As De Valera himself explained during debate over the adoption of the 1937 constitution, women would most generally be ‘supported by a breadwinner who is normally and naturally in these cases when he is alive, the father of the family ... able by his work to bring in enough to maintain the whole household’ (*Dail Debates*, vol.67-8, col.67). Needless to say, day care and similar family services were conspicuously underdeveloped and the principle of ‘subsidiarity’ ensured that the state only interfered when the family’s capacity to service its members was exhausted.

In an attempt to acknowledge the peculiarities of the Irish state and still place it within the general corporatist-statist regime cluster set out by Anderson’s typology, McLaughlin (1993) uses the term ‘Catholic Corporatism’ to highlight the disproportionate influence of Catholicism versus Corporatism in the Irish case. This (relatively minor) conceptual innovation is not, however, sufficient to convince others of the utility of Anderson’s typology in explaining the Irish case. Peillon’s (2001:143-157) arguments against using Esping-Andersen’s ‘corporatist-statist’ framework to explain the Irish case centre around the contradictory character of Irish welfare policies: some policies promote class stratification, whilst others reduce it; some benefits are universal, whilst others residual. Peillon (2001: 150-1) argues that the decommodifying effects of some social programmes are high (unemployment benefit for example), yet for others (such as pensions and sickness insurance) they are low. Moreover, in some areas the state accepts full administrative

responsibilities, in others none, and in some cases social services are provided by a partial state or state sponsored body (Peillon, 2001:152-3). For Peillon (2001:156), the contradictory statistical evidence for Esping-Andersen's classification is not ameliorated by the link that he establishes between the predominance of the Catholic Church and the conservative nature of the corporatist-statist welfare regime. We argue, however, that it is precisely this link that confirms the Irish case. Few typologies are perfectly prescriptive, their significance lies in the way that they can generalise about important variables for analysis. Overall, we believe that it is the *idea* of the 'Catholic Corporatist' state that conveys so much about the Irish welfare state and political system and that enables it to be placed in a comparative context - not only against the performance of other welfare states in other countries, but also against its own past performance, by providing a baseline for more contemporary studies of policy performance in Ireland.

IRELAND AS CATHOLIC-CORPORATIST STATE

This section examines the formative influences on the welfare state in post-independence Ireland according to Esping Andersen's three main historical forces: the pattern of working class formation; the nature of political coalition building in the transition from a rural economy to a middle class society; and the way that past reforms have contributed to the institutionalisation of class preferences and political behaviour. It demonstrates; first that the relative absence of class-based politics in Ireland has been most damaging to the development of the Irish left; second, that the predominance of rural culture in Ireland has helped to bolster conservatism; and third, that the Irish project of 'nation-building', (which deliberately emphasised the importance of Catholicism and Irishness as opposed to Anglo-Irish, or British traditions), effectively reinforced these two features of the Irish polity. Crucially, however, it was the copper-fastening of these values by the populist, republican and catch-all *Fianna Fail* party that enabled them to form an enduring societal vision that was characteristic of post-independence Ireland throughout the 20th century.³

Pattern of working class formation

Cut off from continental influence, the industrial revolution and the plight of the urban working classes were entirely foreign to Irish society. Scant interest was shown in the efforts of continental social reformers and in Ireland even the phrase 'social question' meant for most people the rural problem and not the urban problem as it did elsewhere (MacMahon, 1981:264). Whereas prior to independence, the six northern counties comprised the industrial heartland of the country (O'Connor, 1992), after partition as few as 5% of the population in the rest of Ireland was engaged in manufacturing (McLaughlin, 1993:208). As a consequence, it was the economic interests of the conservative farming classes that initially took precedence in the new state and the labour movement failed to achieve a leading role. In addition, the idea was promulgated that because British rule and the Protestant Establishment had been overthrown, Ireland was somehow a *classless society* (McLaughlin, 1993:209). The fact that this is not true (see: O'Leary, 1990) is less important than the fact that so many believed it to be true and as a consequence, in

³ We would like to acknowledge our gratitude to Peadar Kirby for crystallising our thoughts in this regard.

Ireland *social* class did not translate into class *politics* (Mair, 1992:389). This attitude is borne out by the ‘the striking electoral debility of class-based, left-wing parties’ in Ireland and the fact ‘there is no other single country in western Europe that even approaches the weak position of the Irish left’ (Mair, 1992:384-5).

The fact that the two main Irish political parties are divided by the stances they took in relation to the conclusion of the civil war marks out the chief peculiarity of Irish party politics. It is significant: first, because it marks the relative failure of the left to take hold in Irish politics; and second, because after the initial political upheaval in the post-independence period, there was little of substance to divide the two main political parties. Support for parties of the left has consistently been much weaker in Ireland than in any other European democracy, legislation has been of a relatively conservative character and survey evidence has shown that when Irish respondents are asked to identify where they are located on the left-right spectrum, they place themselves much further to the right, on average, than other Europeans (Coakley, 1993:40). On socio-economic issues, at least, *conservatism* appears to prevail (Coakley, 1993:47) and the two main parties, *Fine Gael* and *Fianna Fáil*, have both been characterized as ‘essentially centre-right in the mould of European Christian Democratic parties’ (McLaughlin, 1993:208; see also: Dooney and O’Toole, 1982).

The transition from rural to middle class society

Without doubt, the preservation and maintenance of conservative values and attitudes in Ireland can be attributed to the predominance of ‘rural culture’ in Ireland. The outlook on life of the farming community, dubbed by Commins (1986:52) as ‘rural fundamentalism’, nourished conservative and authoritarian values in Ireland. Deference - to males and the elderly, to the Church and the school system - is a marked feature of Irish society (Chubb, 1992:17). Even now, despite increasing urbanisation, it is still a misnomer to assume that the values and attitudes of town people are very different to those from the country. At least half of the population of Dublin have moved from the country (many still travel ‘home’ at the weekends) and with the continuous movement from the countryside to the town, there are many urban dwellers who are but slowly becoming town people. In some senses, to try and divide Irish people between urban and rural cultures, is to miss the significance of the great number of those Irish people who are somewhere in between (Chubb, 1992:3-13). The conservative nature of Irish society was further reinforced: geographically, by Ireland’s peripheral existence at the edge of Europe; politically, by the relative failure of socialism to take off in Ireland; and last, but by no means least, socially, by the hegemonic influence of the Catholic Church.

As a consequence, the Constitution of Ireland, which replaced the negotiated Irish Free State Constitution of 1922, was a deliberate attempt to integrate Catholic social teaching into the liberal democratic tradition inherited from Great Britain and was inherently conservative. It is certainly apparent that the rights articles contained in the 1937 Constitution were strongly influenced by Catholic social thought (Whyte, 1980:52-56; McDowell, 1991:255; Gallagher, 1993:54). Article 41 of the Constitution refers to the family as the ‘natural, primary and fundamental unit group of Society’ and that women ‘should not be obliged by economic necessity to engage in labour to the neglect of their duties in the home’. Despite protests about this article, De Valera refused to delete it and, according to Scannell (1988:125), his reasons for refusing show that his vision of the role of woman in Irish society was that of a full-time wife and mother in an indissoluble marriage, having a preference for ‘home duties’ and ‘natural duties’ as a mother (Dail Debates, vol.67-8, col.68).

In post-independence Ireland the middle classes - whether they lived in the town or the country - were more likely to have a rural background than an urban one; they were typically property owners; they were usually self employed, the owners of small businesses, or larger scale farming operations: the majority were practising Catholics. It was the interests and aspirations of these middle classes that prevailed in the social and political organisation of post-independence Ireland.

Institutionalisation of class preferences and political behaviour

The Irish state was, from the beginning, ostentatiously Catholic. Throughout the nineteenth century the power and influence of Roman Catholic Church increased considerably as older traditions and conservative attitudes prevalent amongst the rural Irish became strongly associated with the identification of the nation with the peasantry (Chubb, 1992:14). The influence of the Church was further secured when it became enmeshed with the nationalist struggle, and as Catholicism became an important element in the construction of Irish identity. In contrast to its position in other countries, in Ireland the Catholic Church was not a great landowner and did not cause much envy or discontent amongst the people. Quite the reverse, parish clergy were often local community leaders who not only identified with the agrarian, nationalist aims of the people but often went out of their way to support them. The consequences for the development of political culture in Ireland were significant.

Fanning (2002:31) notes that throughout the nineteenth century profound shifts occurred within Irish nationalism whereby one hegemonic construction of Irishness, which emphasised the Irishness of the minority Protestant elite was gradually displaced by a new Catholic 'Irish-Ireland' nationalist hegemony. The comparatively early development of mass political organisations in Ireland long preceded a belated industrialisation and this fostered a religious-ethnic conceptualisation of nation bound up with kinship ties and peasant tribalisms as opposed to one shaped by class politics and secular modernisation (see also: Hutchinson, 1992:114). Coakley (1993:37) notes that 'while observers are agreed that Irish people by and large accept the principles of liberal democratic government, they have also pointed to certain features of Irish political culture that are of questionable compatibility with democracy'. The importance of authoritarianism, conformism, anti-intellectualism and loyalty have been identified as distinctive elements in Irish political culture (Chubb, 1970: 43-60; 1992: 3-20).

So it was, that in the stead of more radical or reformist social analysis that might have been provided by the secular left, the Catholic Church in Ireland copper-fastened its position as an influential social force and subsequently maintained and protected its influence by demonising 'the evils of socialism' (Larkin, 1985). MacMahon (1981:279) notes that although the clergy were generous and often self-sacrificing in their efforts to help the poor, their response to social misery was determined to a large extent by the prevailing social, political and economic ideas of the time. It was an accepted fundamental belief that there was a natural social order imposed on humankind by the Creator and many clerics were inclined to allocate the responsibility for social problems to 'feckless individuals', wanting in thrift, diligence or common sense (MacMahon, 1981:266).

Since national attention was monopolised by the British connection, there was a loss of contact and interest in continental Europe and 'the national pastime of attributing social and economic evils to English influence provided observers with an easy explanation and an excuse for not analysing the situation at a deeper level (MacMahon, 1981:280). Class consciousness and class-based politics fell victim to

the prevailing attitudes of the time. In Ireland, class distinctions are thought of as a typically English phenomenon. The popular impression is that rigid social class demarcation was left behind with the ending of landlordism and the demise of the Anglo Irish ascendancy (Breen and Whelan, 1996). This has encouraged the notion, put forward earlier, that Ireland is a classless society (McLaughlin, 1993; Breen and Whelan, 1996). Above all others, the *Fianna Fail* party was the most successful in tapping into these notions of Irish political culture and establishing itself as the rightful party of government. ‘Like the populist movements of Latin America, which grew as a response to colonialism, *Fianna Fail* sought to merge class differences in an ideology of national development, which promised gains to all classes. The small Labour Party, which supported *Fianna Fail* in 1932, found it difficult to compete’ (Wren, 2003:30, see also: Kerby, 1998). This problem has been an enduring one for the Irish left.

SUSTAINING CATHOLIC CORPORATISM IN HEALTHCARE

In order to develop the ‘Catholic Corporatist’ case for healthcare in Ireland, the analysis focuses on the chief distinguishing features of the ‘corporatist-statist’ model of welfare outlined by Esping-Andersen (1990). These are: the maintenance of status differentials; social rights strongly attached to class and status; the overall influence of the Church; the preservation of traditional familyhood; the existence of social insurance schemes that typically exclude ‘non-working’ wives and family benefits encourage motherhood; plus the conspicuous absence of day care and similar family services in accordance with the principle that the state will only intervene as an agent of last resort. Clearly, the influence of the Catholic Church has been crucial in maintaining these values.

Fahey’s (1992, 1998) analysis of the influence of the Catholic Church on Irish social policy distinguishes between two broad areas: a teaching influence stemming from Catholic social thought and a practical influence linked to the church’s role as a major provider of social services. He argues that the primary aim of church involvement in social service provision was to ‘disseminate and safeguard the faith, not to combat social inequality or reform society’ (1998: 415). To support his claim, Fahey (1998) points to the churches role in reinforcing pre-existing societal inequalities, particularly in the provision of schools and hospitals. In this regard, the Catholic Church was happy to provide ‘elite’ social services for those who could afford them as well as more broadly based services for the less well off. Thus, whilst the Catholic Church’s role as a provider of social services in Ireland was an ‘extraordinary organisational achievement’ its larger impact on the development of social policy was constrained by its view of such provision as ‘a means rather than an end for the Catholic Church – it was an instrument for the dissemination of faith, not a field of endeavour which was worth pursuing in its own right’ (1998: 415).

In relation to the Church’s ‘practical influence’ on social policy, the authority exercised by the Catholic Church in today’s health service is only a shadow of its former self, largely as a consequence of the declining number of vocations to religious life, the impact of the second Vatican council, the increasing secularisation of Irish life and the creation of a more structured state approach to public health service following the establishment of the Health Boards under the 1970 Health Act (Barrington, 2003: 161-2). In relation to its ‘teaching influence’ however, the Church

is managing to maintain much of its traditional authority in the realm of healthcare through its extensive and persuasive influence over ‘moral and ethical’ issues such as sterilisation, abortion, bio-ethics and through its implicit acceptance of current inequalities in health and society.⁴ Whilst the declining numbers of religious personnel have meant that many of the Catholic voluntary hospitals around the country have been sold by the religious orders in recent years; many of these sales were contingent on a continued Catholic ethos. Until very recently, for example, due to the dominance of Catholic voluntary hospitals in the Dublin area, it was much more difficult for women to undergo sterilisation in Dublin than in other more provincial regions where the large hospitals are publicly owned. Indeed, at present in-vitro fertilisation is only available in two hospitals in Ireland (Wren, 2003; 127).

Wren (2003) argues that the resistance of the Catholic Church in Ireland to health care reforms prior to independence stemmed both from its identification with the interests of property owners and from its ignorance of, or worse its indifference to, the plight of workers. This was possible since, as Fitzgerald (2003) points out, prior to independence the Irish clergy were mainly drawn from the middle class and predominantly the property owners of the Irish middle classes. After independence, whilst the concerns of property owners still loomed large for the Church, the fear of socialism was greater. After World War II in many European states Catholic parties were either left-wing or prepared to align themselves with socialists. In Ireland, however, the Catholic Church ‘retained a deep suspicion of socialism’ and advocated that vocational groups in society, rather than the state itself, should take responsibility for social organisation” (Wren, 2003: 27). Insofar as they were able, early Irish governments attempted to accommodate the Catholic Church view.

From the early 1930s, the government of Ireland made explicit reference to its desire to govern the country according to Catholic principles. This sentiment was typified in 1933 when the then Minister for Local Government and Public Health informed an audience in Geneva that his governments programme of economic and political reform was based on the same principles as the papal encyclical *Quadragesimo Anno* (Barrington, 2003; 157). In fact, up until the 1960s, the Church and its doctrine on all matters concerning the family and society remained unquestioned by society and the political system - confirming the importance of Catholicism in Irish political culture. Indeed, for some time following independence, the desires of the Catholic Church were thought to be synonymous with those of the Irish people. Hussey (1993: 381) suggests that:

The shared experience of a long and weary fight against Britain gave it a central and pivotal role in the life of the people, who fully identified with it and accepted almost without questions its dominance over every aspect of their lives (Hussey, 1993:381).

Though it would be folly to argue for the relevance of Catholic-Corporatism in the Irish case without acknowledging the all-pervasive influence of the Catholic Church, our principle argument is that the importance of Catholicism and Catholic values needs to be understood within the context of other significant features of the Corporatist-statist model. That is, that although the influence of the Catholic Church

⁴ Whilst some members of the Church have occasionally protested at the organisation of the state, such voices of dissent have been few and far between. In relation to healthcare, perhaps the most notable voice of dissent belonged to Bishop Dignan, who in the 1940s condemned the Dispensary System for being degrading and humiliating to ordinary people.

is obvious and central to explanations of Irish welfare state development, in some senses it represents a diversion from the more fundamental insights that may be gained by application of the Corporatist-statist model. The ‘bigger picture’ as our examination shows, is that at every single critical juncture presented by a key legislative moment in the development of Irish healthcare, the prevalence of conservative values combined with the absence of a strong Irish left effectively precluded any widespread consideration of alternative frameworks for the provision of healthcare in Ireland.

The following examination of Irish healthcare is presented via a series of critical junctures:

- The establishment of the dispensary system 1851
- Health care Insurance Act 1911
- Mother and Child Scheme 1947
- Health Act 1970
- Contemporary crisis in Irish healthcare

The establishment of the dispensary system 1851

The health care service provided in contemporary Ireland is rooted in the Irish Dispensary system, created in 1851. The Poor Relief (Ireland) Act, 1851, placed a duty on the Irish Poor Law Commissioners to see that Boards of Guardians provided health care dispensaries and appointed medical officers to each of them. Medical relief, surgery and midwifery services were provided to the poor, who comprised one third of the population at that time (Barrington, 1997). Financed by the poor law rate (a taxation paid by the property owners), each poor law ‘union’ was divided into a number of dispensary districts with their own salaried medical officer, whose priority it was to treat the poor. In addition, doctors were also entitled to attend those outside the ‘union’ in their capacity as a private practitioner. The shortcomings of the system were manifold, in particular the variation by county in the criteria for eligibility for treatment and the lack of choice of doctor for eligible persons. More importantly, by according a different status to fee-paying and non-fee paying patients, the Dispensary System was responsible for formally inculcating the acceptance of unequal status between recipients of Irish healthcare.

Health care Insurance Act 1911

When, in 1911, a modified version of the British Health Insurance Act (providing a form of social insurance to protect against loss of income and medical costs related to illness and unemployment) was proposed for Ireland, the opportunity arose to radically alter the residual and socially stigmatised nature of Irish state healthcare. Contributions to the scheme were intended to be compulsory for employees, in addition to those made by employers and the state. The self-employed would be encouraged to contribute on a voluntary basis and the scheme was to be administered by the friendly societies. This was perhaps the first stumbling block for Irish implementation: friendly societies in Ireland were relatively small scale compared to their British counterparts. The prior existence of the dispensary system provided the second. Since the Dispensary system already provided free medical care to many of the would-be beneficiaries of the proposed legislation, it was easier for those opposed to the bill to argue that the legislation was not appropriate for Ireland

(Barrington, 1987:40) and harder for those in support of the bill to tackle the vested interests that were marshalled against it. Opponents to the bill included the medical profession and the Church.

The medical profession initially opposed the scheme, supposing that it would weaken the private practice of many of the doctors who worked in the dispensary service. The Catholic Church took a much broader view in its criticism of the scheme. Irish Bishops argued that the legislation was inapt because Ireland was not as industrialised as England and Wales, suggesting that the scheme would place an undue financial burden on Irish industry and likely lead to unemployment. Such support as there was came from The Irish Party who, disregarding the concerns of the hierarchy and medical profession, argued for an extension of social provisions for Ireland. The influence of the Irish Party was, however, short-lived and the election of 1918 marked their end as an effective force in Irish politics. Though they succeeded in securing unemployment insurance for workers, opposition from significant sections of the medical profession prevented the adoption of medical benefit to Ireland (Barrington, 2003).

This decision marks Ireland's first digression from the genre of health policy being adopted in Britain and Continental Europe - one in which social insurance based medical benefit became the norm in the majority of countries - and although the debate surrounding free health care for all did not fade away entirely, it was clear from this point on that Irish healthcare would never be universally provided.

1947 Mother and Child Scheme

The origins of the Mother and Child Scheme lie in the early 1940s. In 1943, Sean Mac Entee as Minister for Local Government and Public Health decided that the improvement of the Irish health services was a matter of urgency (Millar, 2003). By 1945, Dr. F.C. Ward, who was given responsibility for health in the Department, had drafted a Public Health Bill with measures for controlling infectious diseases, improved medical inspection in schools and free medical services for (ante and post natal) mothers and children up to the age of sixteen without a means test.

The Church expressed its discomfort with state interference in the medical inspection of children, particularly adolescent girls, regarding the matter as an infringement on the rights of the family. The Hierarchy's greatest objection, however, was to something that was not even stated explicitly in the legislation: that was 'to the dangers posed to the morals of women and children by health education', clearly exposing the extent of Catholic hierarchy doubts about the wisdom of 'exposing Irish women to information about contraception and abortion and children to sex education' (Barrington, 1987: 187). The Catholic Church's position that it was inappropriate for government to 'interfere' in family matters (Whyte, 1980:196-272) has achieved iconic status in all discussions of church and state ever since.

In addition to the objections raised by the Catholic Hierarchy, Ward's proposals were also offensive to the medical profession. For them, it represented the first step toward 'state medicine' or 'socialised medicine'. In particular, they took exception to the Mother and Child sections of the Bill, regarding them as a threat to the income of private practitioners, which in most cases was primarily derived from attending small children. As well as the obvious negative financial implications, the medical profession were concerned that the Mother and Child scheme might be seen as a first step in the direction of a 'National Health Service' for Ireland, comparable to that which was being established in the UK. The IMA believed that 'the strong likelihood was that private practice would gradually be superseded by a salaried state

service' (Lee, 1989:316). The doctors were a powerful group organised to resist such a move, they were suspicious of the means tests and feared excessive political control under a strong minister (Lyons, 1973:577).

In 1947, the fall of the *Fianna Fail* government enabled De Valera to evade the issue, leaving it to the new government to implement Ryan's Health Act (Lee, 1989:315). This new government 'ushered a new era in Irish politics' when *Fianna Fail* were replaced 'by a five-party coalition supported also by independent deputies, the first 'Inter-Party' government' (Coakley, 1999:23). Under the leadership of John A. Costello (*Fine Gael*) the health portfolio fell to *Clann na Poblachta*, a new Republican Party led by Sean McBride who nominated his newly elected colleague Dr. Noel Browne as Minister for Health at the age of 32. In 1950, with pressure mounting from *Fianna Fail* in opposition, Browne decided to introduce the Mother and Child sections of Ryan's 1947 Act. In doing so, Browne's first problem was to deal with *Fine Gael's* opposition to the compulsory and universal nature of the scheme. As result, the scheme was modified and now emphasised three key elements: it was not compulsory; there would be no means test; and no charges for the service. (Barrington, 1987: 200-3). The Irish Medical Association disagreed with the Minister's proposals: dispensary doctors stated that they would not see *poor* patients in their *private* surgeries, designed for *paying* patients.

In the wake of all this opposition, it was clear that by March 1951, Browne was attempting to implement the Mother and Child scheme in the absence of explicit cabinet support and authorisation. Instead he relied heavily on an agreement to amend the Health Act made by government in 1948 (Lee, 1989:317). His authority for action was tenuous and once the Hierarchy had made their views known, Browne's cabinet colleagues pleaded with him to accept the Bishops' ruling. Browne was intransigent, insisting that he was not responsible for the original law and that he alone could not make a new one (Browne, 1986:170). On 11th April 1951, at the insistence of his own party leader, Sean McBride, Browne was obliged to resign (Lyons, 1973:578).

1953 Health Bill

Shortly after Browne's resignation the coalition fell and *Fianna Fail* returned to power, leaving them with the responsibility - once more - for passing even more dilute versions of the Mother and Child Scheme into law. Based on an income threshold guaranteeing around 80% of the population's eligibility, the 1953 Health Bill made provision for free health care for mothers before and after birth and for infants up to six weeks of age, plus limited public health treatment for children up to six years of age (comprising bi-annual health checks plus immunisation and vaccination services). This politically popular expansion of free health services was significant, first in removing a large part of the would-be constituency of support for health care reform, and second in crystallising the Irish Medical Association's (IMA) position on the provision of health care in Ireland.

The IMA, seeing the provisions of the Bill as a threat to their membership's capacity to generate income from private patients, proposed the establishment voluntary health insurance as a way covering the hospitalisation costs of the 15-20 per cent of the population who were not eligible for free public hospital services. Since higher income groups could now insure themselves against the costs of private medical treatment, Wren (2003:42) argues that this was also in effect insurance for the medical profession that their private income would be secured. The establishment of Voluntary Health Insurance in 1957, effectively cemented a two-tier system of

public and private hospital care - a duality that was to be further embedded into the system with the 1970 Health Act

This was established in 1957, effectively creating a two-tier system of public and private healthcare - though there are actually two categories of eligibility for state provided services, 'full' and 'limited'. Full eligibility is available, subject to an income limit, to 'adult persons unable without undue hardship to arrange general practitioner, medical and surgical services for themselves and their dependents'. Individuals in this category are entitled to the full range of health services without charge. Limited eligibility is available to people whose income is above the established threshold for full eligibility. They are entitled to free hospital care (there is a nominal nightly 'bed fee' or accommodation charge), specialist services in out-patient clinics, and maternity and infant welfare services. This duality was further embedded into the system with the 1970 Health Act.

Health Act 1970

Throughout the 1960s there were calls from opposition parties, in particular the Labour Party, to extend the provisions of the 1957 Act. In 1959, the Labour Party proposed a free health service funded by taxation and insurance contributions. *Fine Gael* advocated a system in which 85 per cent of the population would be entitled to such a service. Wren (2003) notes, however, that even *Fianna Fail* - the party who initially proposed free health care - no longer viewed it as an important objective. In 1966, Donogh O'Malley as Minister for Health published a White Paper, *The Health Services and their Further Development* (Department of Health, 1966). The White paper proposed the replacement of the Dispensary System with one where patients would be entitled to a choice of doctor. It did not advocate state organised medicine and the proposals were confined to those in the lower income groups for whom the cost of doctor's fees and medication would cause undue hardship (Hensey, 1988). As the Minister for Health stated in the *Dáil* during the debate of the Health Bill in 1969:

the present government has not accepted the proposition that the State had a duty to provide unconditionally all medical, dental and other health services free of cost for everyone. Their policy has always been to design services and the provisions on eligibility for them on the basis that a person should not be denied medical care because of a lack of means, but the services should not be free for all (McKevitt, 1990:5).

Thus, in Ireland it was only the destitute who received care from the dispensary service and free access to health care was not regarded as a right for all. Unlike the systems of health care developed in other countries, where health services are free at the point of access, in Ireland the principle of the means test for accessing health services became enshrined in the Irish health care system. Together, the desire of the medical profession to remain outside the direct employment of the state and the concerns of the Catholic Church surrounding socialism, ensured that the maintenance of status differentials and the granting of social rights that are strongly attached to class and status thus became a significant feature of the Irish healthcare system.

Still regarded as the cornerstone of contemporary services, the 1970 Health Act was introduced by the then Minister for Health as the 'most rational solution to a number of problems' (Barrington 1997:271), many of which stemmed from the

manner in which health services had been provided within the former Dispensary System. The Act proposed the establishment of a new management structure for health services, devolving responsibility for the administration of healthcare to newly created Regional Health Boards, thus imposing a structure to healthcare services where none had previously existed. Included in the Act was the establishment of the General Medical Services (GMS) card which was innovative in that an eligible person no longer attended a dispensary but visited the doctor of their choice, in the same facilities as private patients (Hensey, 1988). Full eligibility is available, subject to an income limit, to 'adult persons unable without undue hardship to arrange general practitioner, medical and surgical services for themselves and their dependents'. Individuals in this category are entitled to the full range of health services without charge. Limited eligibility is available to people whose income is above the established threshold for full eligibility. They are entitled to free hospital care (there is a nominal nightly 'bed fee' or accommodation charge), specialist services in out-patient clinics, and maternity and infant welfare services.

This meant that despite the two-tier system, by and large, public and private health care are provided in the same hospitals and by the same consultants and nurses. In this respect, perhaps one of the more progressive elements of the 1970 Health Act was the stipulation that both public and private patients be treated in the same premises by their GP. Notwithstanding this improvement, the maintenance of status differentials between public and private patients was still a defining feature of the system.

Contemporary crisis in Irish healthcare

Everyone in Ireland is entitled to free hospital care, yet still 45 per cent of the population are members of private health insurance schemes. Since its establishment in 1957, the membership of (Irish) Voluntary Health Insurance (VHI) has steadily increased: by 1967, 300,000 individuals had private cover; by 1977 this had increased to 600,000. In recent years, growth has been exceptional and it is currently estimated that in excess of 1.5 million individuals (nearly 42 per cent of the population) have private health insurance (Department of Health and Children, 1999). This growth has been attributed to the increased number of people in employment, and the provision of health cover as an employee benefit by many companies - something estimated to account for 20 per cent of all premiums to private health insurers (Millar, 2004).

This 'imbalance' comes at a significant cost. Health care funding derived from private health insurance contributes only 9 per cent to the total expended, yet this small contribution guarantees its members a real and tangible benefit: speedier access to hospitals. Since, however, health insurance does not pay the full economic cost of the use of hospital beds, private hospital treatment continues to be heavily subsidised by all taxpayers. Public hospitals get back only half the cost of caring for private patients from the insurance companies. If the full economic cost were to be met, a 25 per cent rise in premiums would be needed. Moreover, there is a further loss to the exchequer, in that health insurance subscribers receive tax relief on their premiums as an incentive to sign up. As the increase in numbers subscribing to health insurance in Ireland seems set to continue, private health care as it exists in its present form may not be sustainable in the longer term (Millar, 2004)

In 1999, the Society of Actuaries, in a submission to the government's White Paper on private health insurance (Department of Health and Children, 1999), argued that the 'symbiotic relationship that has developed is beginning to eat away at the

system' (Kerby, 1998). In other words, whilst the availability of private health insurance has eased the pressure on the public services, ironically its success in enabling 'queue jumping' over public patients could also be its ruination, since the more members that join, the more pressure there is on hospital beds and services. This, the Society argues, could eventually lead to waiting lists for private patients and remove the very rationale for people subscribing to such insurance.

Moreover, as contemporary Ireland had become more economically successful, income disparities have increased. This has led to the emergence of what former *Taoiseach*, Garret FitzGerald, terms as a 'three-tier health care system' (2001). This is because as employment levels have increased, fewer families and individuals are eligible for the GMS cards that entitle them to a full range of health services without charge. Whilst 30 per cent of the population are still covered by the GMS, with some 45 per cent or so in private health insurance, there remain 25 per cent of people who have neither medical cards nor any kind of insurance. The individuals who constitute this group must of course pay for every GP visit, but will receive free hospital care for a nightly 'bed fee'. The IMO estimates that 250,000 people are unable to afford health treatment yet the government does not intend extending the eligibility threshold for the GMS before the end of 2003, due to budgetary considerations. At its 2001 Annual Meeting the IMO called for a change in the way the GMS is operated; in particular, the IMO has called for free GP care to be extended to all citizens on low incomes especially to those families with young children. Still, current government health strategy does not envisage any structural change to the public-private mix in Irish health care.

CONCLUSIONS

Using a historical institutionalist approach, we argue that the contemporary crisis in Irish healthcare represents the logical outcome of a path-dependent trajectory of reform, that is, one where the Catholic Corporatist values that predominated in the post-independence period have left an enduring legacy for the organisation of contemporary healthcare in Ireland. Aside from the significant impact of the Catholic Church in defining and establishing the shape and extent of the present healthcare system, application of the corporatist-statist model illustrates how Irish conservatism has ensured that the primacy accorded to the preservation of status differentials has come at the cost of considering any alternative more economically viable system of healthcare provision.

Despite the obvious indicators that a crisis is imminent, calls for reform have been limited and proposed primarily by the Irish left. Only the Labour Party has proposed any significant reform to this system, suggesting the extension of the insurance system to cover everyone in the state, with the state paying the premiums for those who cannot afford them. Within this system, the Labour party propose the creation of a universal hospital system which would treat all patients equally regardless of whether they themselves or the state pay the premiums and a 'super-private' system in which private practice would be removed from public hospitals and such doctors would not be permitted to work in state hospitals. The current government's health strategy does not, however, envisage any structural change to the public-private mix in Irish health care.

Application of the corporatist-statist model further illustrates how the weakness of the Irish left has ensured that any concerted political campaign for

reorganisation of the health service has been largely absent from contemporary debate. Instead, the hegemonic influence of *Fianna Fail* has managed to capitalise on ‘cross-class, non-ideological and integrationist reflexes of populism’ (Kirby, 2003) in the preservation and maintenance of the incumbent system, despite its conspicuous flaws when compared with nearly every other European system of national healthcare. The fact that reform of the current set up has received such scant attention or recognition provides yet more evidence for our supposition that the ‘Catholic Corporatist’ paradigm is still a fruitful one in investigations of the Irish welfare state.

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