

Health Policy and the Policymaking System: A Case Study of Primary Care in Ireland

Niall Kelly, John Garvey & Donal Palcic

Kemmy Business School, University of Limerick

Abstract

In 2001, the Irish government published a reforming policy intended to modernise and expand the delivery of primary care in Ireland. Fifteen years later, the Irish health system remains beset by problems indicative of a fragmented and underdeveloped primary care system. This case study examines the formation and implementation of the 2001 primary care policy and identifies key risk categories within the policymaking process itself that inhibited the timely achievement of policy objectives. Our methodology includes a directed content analysis of the policy formation and implementation documents and the influencing academic literature, as well as semi-structured interviews with key personnel involved in the process. We identify three broad risk categories - *power*, *resources* and *capability* - within the policymaking process that strongly influenced policy formation and implementation. We additionally show that the disjoint between policy formation and policy implementation was a contested issue among those involved in the policy process and provided space for these risks to critically undermine Ireland's primary care policy.

Keywords: primary care; policy making; health policy; risk; Ireland

1. Introduction

In common with developments in other European countries and internationally, Ireland has attempted to reform its primary care infrastructure in recent years. Ireland's foundational policy document on primary care reform, entitled *Primary Care: A New Direction*, was published in 2001 [1]. A key motivation for the new policy was the recognition that (i) existing primary care infrastructure was poorly developed, (ii) services were fragmented with little teamwork, and (iii) secondary care was providing many services that were more appropriate to primary care [1]. The policy was introduced as part of a new over-arching health policy for Ireland [2] which committed to improving equity of access to health services and creating a more 'people-centred' high quality system of delivery.

To address the above issues the new policy proposed making primary care the central focus of the health system and main point of entry to all health and personal social services. An inter-disciplinary primary care team (PCT) was identified as the core health service unit that would be tasked with meeting the health and social care needs of a specific population. The plan also proposed the establishment of wider primary care networks of other health professionals to support a number of core PCTs in given areas. It was envisaged that approximately 600-1000 PCTs would be required nationally, with a goal of achieving two-thirds of implementation (400-600 PCTs) by 2011 [1]. Unfortunately, progress to date in rolling out the Government's primary care strategy has been very slow with most of the original targets missed and the Irish health system is still beset by issues that stem in part from a fragmented primary care infrastructure.

This paper examines the processes that framed the formation and implementation of the 2001 primary care policy and the degree to which risks to policy failure were addressed. Ireland experienced unprecedented political stability and strong economic growth for seven years following the publication of the primary care policy. The failure to meet the targets set out in the original policy provides a strong motivation to assess potential 'process failure' risks, within the policy making system. Our methodology incorporates a directed content analysis of all of the Government documentation related to the formation and implementation of the policy as well as semi-structured interviews with key participants in the policy making process. We find that there was a considerable disjoint between policy formation and implementation and we identify three broad risk categories - *power*, *resources* and *capability* - within the policymaking process that strongly influenced its development.

Our research addresses an often overlooked area of health policy research [3,4], particularly in an Irish context, where MacCarthaigh notes that “we do not know enough about the Irish policy-making process as there has been little if any fundamental research conducted” [5]. The primary care initiative is an ideal subject matter as it stands as a distinctive and reforming policy in recent Irish political history and in the provision of health care services.

The paper is structured as follows: the next section provides a brief overview of the international literature on primary health care as well as some of the recent Irish literature on primary care and health policy in general. Section 3 outlines the key objectives and targets of the 2001 primary care policy initiative in Ireland, the progress in implementing the policy and meeting the 2011 targets, and some of the key issues that confounded the policy’s implementation. Section 4 describes our methodology which incorporates a directed content analysis of published and unpublished policy-related documents, along with semi-structured interviews with key members of the policy implementation steering group. Section 5 provides a detailed discussion of our findings and section 6 concludes.

2. Literature review

It is now well recognised internationally that strong primary health care systems are imperative if countries are to deal with the pressure arising from continuous demographic and socio-economic changes. There is a considerable body of evidence that shows that countries with strong primary care systems generally have healthier populations, more equitable access to health services, and lower overall costs for health care [6,7,8]. The positive evidence in relation to primary care reform and improved equity in health is particularly relevant to the subject of this study where the radical reform of primary care services was central to the goal of reducing health inequalities that underpinned the Government’s overarching health strategy introduced in 2001.

Despite the strong evidence in favour of primary care reform and calls by bodies such as the WHO for countries to strengthen primary care systems [9], the development, organisation and strength of primary care systems to date varies widely across countries [10,11,12]. Historically in most countries in Europe, GPs have remained the gatekeepers to further specialised care and secondary care and this remains the case in many national health systems today. In recent years, however, a considerable number of countries have moved to integrate specialised nursing and additional professions with GP services to form more comprehensive

and coordinated primary care teams in the community. The content and extent of primary care reform policies across European countries differs substantially as a result of the historical development and institutional structure of each country's health care system [12,13]. In addition, macroeconomic conditions, as well as labour and social policies in each country, can also enhance or diminish the effectiveness of a primary care reform policy.

In terms of the Irish literature, much has been written on the broader developments in Irish health policy and services, particularly since the economic crisis of 2008 which has had a severe impact on the provision of health services (14,15,16,17,18). There have also been numerous policy studies that focus on narrower aspects of the health service in Ireland. For example, McHugh et al. conducted an analysis of the policy-making process related to diabetes care [19], while May et al. conduct a detailed analysis of palliative care policy reform since 2001 [20]. The latter paper adopts a similar approach to our own in that the authors perform a content analysis of all relevant policy and service documents developed at a national and regional level, as well as relevant academic articles on palliative care in Ireland. The authors found that policy goals could not be realised largely as a result of a shortfall in committed resources, a finding that resonates with our own results which are discussed later.

With regard to primary care reform in Ireland, while there have been a number of reports by government bodies and other groups such as the Irish College of General Practitioners on the experience with reform since 2001, the policy has received very little attention in the academic literature. O'Sullivan et al. conducted a review of peer-reviewed publications and the grey literature related to PCTs, the primary care reform process and interdisciplinary working in PCTs over the period 2001-2012 [21]. The authors found that there was a lack of comprehensive research in relation to PCTs in Ireland and noted that it would be valuable to conduct "a major theoretically informed analysis of the implementation journey of primary care teams in Ireland" [21]. Our paper addresses this critical issue and makes a significant contribution to the Irish and international literature where, to the best of our knowledge, our paper is the first in-depth case study of how risks to policy failure were addressed in the policy formation and implementation process for primary care services in any country. The next section describes the 2001 primary care reform policy in more detail and outlines the implementation of the plan up until 2011 (a key implementation milestone year within the

policy and also when a new Government was elected and introduced major health policy reforms).

3. Primary care reform in Ireland

The core operational element of the 2001 primary care reform policy was the planned creation of inter-disciplinary PCTs that integrated GPs with nurses/midwives, health care assistants, home helps, physiotherapists, occupational therapists, social workers and administrative personnel. These PCTs would be supported by wider primary care networks including professionals such as psychologists, speech and language therapists, dieticians, dentists, chiropodists, pharmacists and community welfare officers [1]. The plan assumed that approximately 600-1000 PCTs would be required nationally over the long-term (based on a 3.8 million population). Initially, the model was to be implemented on a phased basis through a small number of pilot implementation projects but with the expectation that by 2011, two-thirds of full implementation would be achieved. Specifically it was expected that between 400 and 600 fully functioning primary care teams with wider providers' networks would be operational by 2011. The target number of PCTs to be established was revised a number of times after 2001 as the size of both the target population groups for each PCT were changed and Ireland's overall population grew. By 2010 the target number of PCTs was 527 [22].

Evaluating the success of primary care implementation in Ireland is complex as the stated policy goals were inevitably affected by demographic and economic trends over the planned period of implementation. Demographically, Ireland experienced rapid growth in its population from the mid-1990s onwards, driven by significant net immigration up until 2009 and one of the highest fertility rates in the EU [14]. On the macroeconomic side, Exchequer finances benefited considerably from significant economic growth as a result of a major property bubble that began in 2003 but subsequently collapsed with the onset of the global financial crisis in 2008. This precipitated a major economic crisis which required a bailout from the so called 'troika' (ECB, EC and IMF) in 2010 and a significant programme of austerity that led to severe cuts across all public services (particularly in health) and drastically curtailed any additional investment.

Notwithstanding the above issues, the progress by 2011 in achieving the stated objectives and targets of the 2001 primary care policy was disappointing. By September 2008, just 81 PCTs

were reported as functioning and holding clinical team meetings [23]. By the end of 2009, 222 PCTs had been established but only 112 of these were holding clinical team meetings [24]. By the end of 2011, 425 PCTs were in operation and described as being at “various stages of maturity and development” [25]. However, there is evidence to suggest that primary care services at that point were fragmented with a high proportion of GPs working within primary care teams stating that the teams were not working successfully. For example, in a survey of Irish GPs in 2010, just 36% of GPs indicated that their practice was functioning as part of a PCT [26]. However, the same survey also showed that only a small percentage of practices included other types of health care providers besides a practice nurse and that only 44% of respondents indicated that they believed PCTs would enhance their ability to deliver chronic disease management within their practice. A subsequent survey undertaken by the Irish College of General Practitioners (ICGP) in October 2011 revealed that 46.1% of those surveyed were participating in a PCT, however, the majority of this number (64.6%) reported that theirs was a poorly functioning team [27]. Moreover, the vast majority of the PCTs that had been established by the end of 2011 were ‘virtual’ teams with no shared physical infrastructure.

Notwithstanding the impact of the economic crisis which led to severe cuts in government health-related expenditure, the poor implementation of primary care reform in Ireland outlined above raises questions around possible failures in the policymaking and implementation process and whether some of the risks to successful reform could have been identified and addressed at an earlier stage. It is this aspect of the reform process that commands the focus of this paper and the next section presents our methodology.

4. Methodology

Our methodological approach centres on a directed content analysis of the main Government documents and reports that informed policy formation and implementation along with semi-structured interviews with key participants in the policy making process. Within the health policy literature, directed content analysis has been successfully applied by numerous authors that have examined elements of the policy formation and implementation process over the years [20,28]. Our approach is best understood in three interconnecting steps illustrated in figure 1.

Insert figure 1 around here

The first step in our methodology involved collecting the relevant documentation used by the Government in the formation of the 2001 policy. Following a freedom of information request, the Department of An Taoiseach (Head of Government) supplied the two documents that were used by the most senior government policymakers as part of the formal Government decision-making processes. These documents consisted of a three page *Summary of Memorandum for Government – National Health Strategy* and a two page document entitled *Aide Memoire for the Government – Re: Preparation of New Health Strategy*. This represented the entirety of the documentation which was found by the Department as being available to the most senior government policymakers at that time for consideration as part of the formal Government decision-making processes.

The Department of Health identified two documents which were specifically considered by the Department to have been foundational to developing the policy. The first of these documents, entitled *Primary care - A summary of the evidence for change*, was a short document (13 pages) that included extensive references to 44 published peer-reviewed research papers in the area of primary care. The second document, entitled *International models of team based primary care*, was similarly brief (9 pages) and sets out the development of primary care capabilities in other jurisdictions. Using these policy forming documents as well as the extensive academic literature cited in those documents we carried out a directed content analysis which led to the identification of a set of *a priori* themes related to risk (see table A1 in appendix).

The second step in our methodology involved undertaking a further detailed content analysis of the documentation analysed in the previous step along with published and unpublished documents relating to the implementation of the 2001 policy using the *a priori* themes developed previously as a guide. Documents from the policy implementation stage were provided by the Department of Health and Children and came in various forms including; minutes of meetings, correspondence, position papers, progress reports, meeting agendas, etc. These were in many instances, voluminous in nature and largely uncategorised and required a filtering activity which resulted in the selection of only those documents which were relevant to the research. Most of the documentation related to the 2001-2005 period before the responsibility for implementation was transferred to the Health Service Executive (created in 2005). We also sourced and included other material related to the implementation phase

including testimony to parliamentary committees on health, as well as speeches by those involved in the policy implementation process.

A content analysis of the above documentation allowed us to further refine our *a priori* themes into a set of codes that highlighted issues that were expected to emerge (formation) or emerged (implementation) during the 2001 policy process. The iterative approach that was followed during this phase of analysis, which is similar to that described by Krippendorff, involved coding the documentation initially using a descriptive approach to indicate what was transpiring in the narrative [29]. This was then refined and amended through the use of memos, annotations and constant revision to create focused codes which reflected themes which were supported by the data (see table A2 in appendix for a list of the refined codes).

The third step in our methodology involved semi-structured interviews with high-level participants in the policy formation and implementation process. Our interview sampling plan was designed to maximize the diversity of the sample around the location of interviewees within the policymaking process (either in formation, implementation or both) as well as their representative group (political, health, administration). A detailed description of the key roles played by each interviewee in the policy formation and implementation process is contained in Table 1.

The interviews involved a combination of open-ended questions and targeted questions guided by the codes that were generated in the previous steps. The interviews lasted between twenty-one minutes and fifty-seven minutes, depending on the time available to the interviewee and the amount of information that the interviewee wished to share during the interview. All of the interviews took place in 2013, with the exception of one which took place in 2015. This raises an obvious possible concern over the fact that more than a decade had passed since the primary care policy had been developed and the interviewees' recollection and interpretation of events could have altered in the interim. However, when questioned about this issue none of the interviewees found the passage of time to be a serious impediment to their recollection of the topics which the interviews explored. Moreover, in triangulating the data gathered during the interviews with that obtained from the documentary sources there were very good levels of agreement, indicating that the passage of time had not diminished the interviewees' recall of events.

Insert table 1 around here

The final phase of the analysis consisted of a content analysis of the output from the semi-structured interviews. Using an iterative process the data from the interviews was combined with that from the documentation to yield a set of broad risk categories that provided the strongest fit to both the documentary evidence and the experiences of those involved in the formation and implementation of the primary care policy. The next section presents and discusses our overall findings.

5. Results and discussion

Parsing the themes emerging from our documentary and interview analysis we identified three closely connected core risk categories within the policymaking process. These categories are *power*, *capability* and *resources*. We discuss each of these categories in turn using some of the evidence that emerged from interviews as a means of illustration. To preserve anonymity, interviewees have been assigned a random number between 1 and 7 and responses are labelled accordingly.

Those charged with overseeing and reporting on the implementation of the policy reveal that *power* was systematically contested or dissolved during the course of policymaking, as exemplified in the following statement:

It's a somewhat nebulous, slightly mysterious process. Obviously things happen, things get decided and things get done but you would always be hard pressed to identify a clear chain of decisions and actions that have flown from a particular policy (Interviewee #4)

In relation to *power*, interviewees repeatedly and consistently referred to political will and motivation, making comments such as:

international research would say that a good, robust primary care system will deliver better outcomes into the future. But you have to make sure the political will is there to be able to do it. (Interviewee #5)

The *power* of political actors relating to the position of GPs emerged as significant risks:

I don't honestly believe that the primary care strategy...had the political support that is necessary to bring about the level of change envisaged, that political support is not...necessarily in terms of financing, but it is also necessary in terms of tackling some holy grails (referring to the position of GPs) (Interviewee #3)

It is clear from the evidence that the issue of power significantly affected policy implementation. This is because successful implementation required political support and empowerment for those charged with realising the policy objectives.

The *capability* of the policymaking system to create effective structures through which the policy could move to successful implementation process was particularly important:

"the pilot sites created an expectation that wasn't delivered on" (Interviewee #5)

initially the department had a year or two in terms of the roll out. With the best will in the world the department didn't have operational capacity. It had an analytical capacity, strategic development capacity but not an operational capacity in so far as itself it couldn't do the work. It could do the frameworks and what resources could be made available to the health boards and so on like that or the various primary care teams. It could do the overall, sort of saying OK we'll do twelve centres this year kind of thing but operationally on the ground it had to be implemented by... the HSE. (Interviewee #6)

This latter statement is reflective of one of the main findings from this research, which is that policy formation and policy implementation were seen and operated as two distinct processes. Risks to successful policy implementation were not successfully considered and addressed when forming the policy and importantly the structures or tools that were in place to address, manage or overcome risks when they did arise were inadequate. When risks to the policy did arise, then they were addressed by those charged with the implementation, with little documentary evidence of an integrated approach to risk management using a specific, focused plan of action for addressing the risks.

Resources emerged as the third core risk category within the policymaking process. The lack of clarity around the additional *resources* required to implement the primary care policy created a destabilising effect within the policymaking process, this is captured by a key policymaker observing that:

I think the issue at the time was the implementation. ...is it implementable, and the biggest factor there was cost, for us anyway, that's the big risk we saw, if you'd even call it a risk. We saw it as more of a challenge. (Interviewee #1)

When the policy did move to the implementation phase, this uncertainty critically undermined the confidence of those participating in the policymaking process and motivated them to move to defensive positions rather than work to pursue a policy they acknowledged to be a good one:

the Minister for Finance of the time, quite clearly through his PR machine made it known that (the) level of funding was not going to be found or allocated over the required number of years, and therefore, the strategies will have to wait and be implemented in a slower pace or incrementally or whatever. So when that political statement was made, I think many of us felt that the Minister for Health was severely curtailed or compromised or limited by what could have been done (Interviewee #3)

The recognition that risks around *resources* and *capability* were not addressed during policy formation but were dealt with in the politically fraught implementation phase is again recognised in the following comment:

What happened between 2001, when the primary care strategy was launched, and 2005 believe it or not, nearly 4 years, was that the department literally put it in cold storage outside the door, and yet wanted us to commit to implementation groups and working parties to implement the primary care strategy. But it was a very unequal sort of an input into policy. (Interviewee #7)

It is useful to note that, the fundamental policy objectives were supported universally by those engaged within the policymaking process. However the clear articulation of the risks to successful implementation within the early phases of policy development is consistently acknowledged by all interviewees and captured in this comment:

the failure to roll out the strategy reflects weakness in the original strategy document, the high ratio of rhetoric and aspiration to practical, relevant detail focused on the everyday reality of primary care in Ireland. (Interviewee #4)

The overarching health care policy was presented as a values-based approach to health care provision as signalled in the Minister of Health's opening statement to the overarching health strategy document published in 2001: "Our health care system must reflect our national values: our concerns for equity, our commitment to diversity, our determination to end

poverty and disadvantage” [2]. In common with the experience internationally, the concept of equity imbued in health policymaking is matched by poor definitional precision as to what equity means and is supported by Smith’s observation that, “it is difficult to identify the overall equity principle underpinning Irish health care policy” [31]. The unsuccessful definition and communication of the meaning of equity in relation to health care was subsequently identified as one of the barriers to the successful implementation of the 2001 strategy [32,33,34,35].

It should be noted that successfully framing and delivering health equity on to the policy agenda is not a uniquely Irish challenge [4]. Our findings provide a deeper insight into the policymaking process and identify the absence of a strong connection between policy formation and policy implementation as a critical risk. While the aspirational and somewhat vague language adopted early within the policy forming phase can be understood as an approach to create impetus for policy adoption, it can critically undermine later implementation. This is neatly captured in the following contrasting observations;

the realpolitik of our health care system and so on wasn’t addressed, and the realpolitik of financing wasn’t addressed (Interviewee #3)

and the acknowledgement from the policy forming phase that:

we didn’t see risks in it [the primary care model] other than the cost issue ..., how do we finance this in future, what model do you develop to finance it? There were risks in terms of the financial model, there were risks in terms of ... can we optimally fund the bells and whistles? (Interviewee #1)

6. Conclusions

Primary care reform in Ireland was framed as a policy that would affirm the nation’s commitment to equity and reducing socio-economic disadvantage. Those tasked with steering the implementation of a major component of the policy universally accepted the potentially positive impact of a health system founded on strong primary care. Despite this we find that the structure of the policymaking process itself was a significant contributing factor to policy failure, thus bridging a gap in the health policy literature and extending the findings of

Kringos [36] and Kringos et al. [10,11] into the factors constraining the development of optimal primary care systems.

Our analysis shows the important role of the Steering Group at the juncture between policy formation (the point where primary care was approved by Cabinet) and policy implementation. The group members' experiences captured in the interview data resonate with Exworthy's observation that the distinction between policy "formulation and implementation is rarely clear-cut" [3]. In the case of the 2001 primary care policy this emerges as a weakness within the policymaking process itself. As one interviewee noted, the requirement was for the Primary Care Task Force to "develop the policy" as it went about its work because "a whole range of operational, practical questions arose". This created the space for stakeholders to attend to the requirements of their respective constituencies, rather than facilitate and lead a well-defined path towards implementation. This overarching finding suggests the need for a much stronger evaluation of risks within the policy formation phase and a need to develop *ex-ante* a set of clear resolution mechanisms for the specific risk categories of *resources*, *capability* and *power*.

Our findings also support and extend May et al.'s recommendation that 'priority is given to feasibility and evidence in compiling a plan' [20]. Our evidence shows that 'feasibility' in the form of *resources* was not considered when the primary care policy was being developed. One recommendation to address this issue would be that senior representation from the Department of Finance be involved at both the policy formation and implementation stages for major policy initiatives so that the key risk categories of *resources* and *power* can be somewhat mitigated. Within the *capability* category, the interview data points to the role of civil servants in planning and moderating of the policy development process. Their activity in managing information flow and maintaining momentum of a policy's evolution is not explored in detail in this paper and is worthy of future study.

References

- [1] Department of Health and Children. Primary Care: A New Direction. Dublin: Department of Health and Children, 2001. Available at: <http://health.gov.ie/blog/publications/primary-care-a-new-direction/>
- [2] Department of Health and Children. Quality and Fairness: A Health System for You. Dublin: Department of Health and Children, 2001. Available at: <http://health.gov.ie/blog/publications/quality-and-fairness-a-health-system-for-you/>
- [3] Exworthy M. Policy to tackle the social determinants of health: using conceptual frameworks to understand the policy process. *Health Policy and Planning* 2008; 23:318-27.
- [4] Embrett M, Randall G. Social determinants of health and health equity policy research: exploring the use, misuse, and non-use of policy analysis theory. *Social Science & Medicine* 2014; 108:147-55.
- [5] MacCarthaigh M. Reform of public policy-making in Ireland. *Journal of the Statistical and Social Inquiry Society of Ireland* 2013; XLII:89-95.
- [6] Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1988. *Health Services Research* 2003; 38:831-65.
- [7] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *The Milbank Quarterly* 2005; 83:457-502.
- [8] Kringos D, Boerma W, Hutchinson A, van der Zee J, Groenewegen P. (2010). The breadth of primary care: a systematic review of its core dimensions. *BMC Health Services Research* 2010; 10:1-13.
- [9] WHO. The World Health Report 2008: primary health care now more than ever. Geneva: World Health Organization, 2008.
- [10] Kringos D, Boerma W, van der Zee J, Groenewegen P. Political, cultural and economic foundations of primary care in Europe. *Social Science & Medicine* 2013; 99:9-17.
- [11] Kringos D, Boerma W, Bourgueil Y, Cartier T, Dedeu T, Hasvold T, et al. The strength of primary care in Europe: an international comparative study. *British Journal of General Practice* 2013; 63:742-50.
- [12] Groenewegen P, Heinemann S, Greß S, Schäfer W. Primary care practice composition in 34 countries. *Health Policy* 2015; 119:1576-83.
- [13] Groenewegen P, Dourgnon P, Greß S, Jurgutis A, Willems S. Strengthening weak primary care systems: steps towards stronger primary care in selected Western and Eastern European countries. *Health Policy* 2013; 113:170-9.
- [14] Briggs ADM. How changes to Irish healthcare financing are affecting universal health coverage. *Health Policy* 2013; 113:45-9.

- [15] Burke S, Thomas S, Barry S, Keegan C. Indicators of health system coverage and activity in Ireland during the economic crisis 2008-2014 – from ‘more with less’ to ‘less with less’. *Health Policy* 2014; 117:275-8.
- [16] Burke S, Normand C, Barry S, Thomas S. From universal health insurance to universal healthcare? The shifting health policy landscape in Ireland since the economic crisis. *Health Policy* 2015, <http://dx.doi.org/10.1016/j.healthpol.2015.12.001>
- [17] Nolan A, Barry S, Burke S, Thomas S. The impact of the financial crisis on the health system and health in Ireland. Copenhagen: WHO Regional Office for Europe / European Observatory on Health Systems and Policies; 2014.
- [18] Thomson S, Jowett M, Mladovsky P, editors. Health system responses to financial pressures in Ireland: policy options in an international context. Copenhagen: WHO Regional Office for Europe / European Observatory in Health Systems and Policies; 2014.
- [19] McHugh SM, Perry IJ, Bradley C, Brugha R. Developing recommendations to improve the quality of diabetes care in Ireland: a policy analysis. *Health Research Policy and Systems* 2014; 12:53. DOI: [10.1186/1478-4505-12-53](https://doi.org/10.1186/1478-4505-12-53)
- [20] May P, Hynes G, McCallion P, Payne S, Larkin P, McCarron M. Policy analysis: palliative care in Ireland. *Health Policy* 2014; 115:68-74.
- [21] O’Sullivan M, Cullen W, MacFarlane A. Primary care teams in Ireland: a qualitative mapping review of Irish grey and published literature. *Irish Journal of Medical Science* 2015; 184:69-73.
- [22] Comptroller and Auditor General. Report of the comptroller and auditor general 2010, volume 2: vote management, chapter 43. Dublin: Comptroller and Auditor General; 2011.
- [23] Health Service Executive. Submission to Joint Committee on Health & Children on primary medical care in the community, 31 October, 2008. Available at: <http://www.oireachtas.ie/documents/committees30thdail/j-healthchildren/submissions/primaryhealthcare/HSE1.pdf>
- [24] Joint Committee on Health and Children. Second Report: Report on Primary Medical Care in the Community, February, 2010. Available at: http://www.oireachtas.ie/documents/committees30thdail/j-healthchildren/reports_2009/20100210.doc
- [25] Health Service Executive. Annual Report and Financial Statements 2011. Dublin: Health Service Executive; 2012.
- [26] Darker C, Martin C, O’Dowd T, O’Kelly F, O’Kelly M, O’Shea B. A national survey of chronic disease management in Irish general practice. Dublin: Irish College of General Practitioners; Department of Public Health & Primary Care, Trinity College Dublin; 2011
- [27] ICGP. Primary care teams: a GP perspective. Dublin: Irish College of General Practitioners; 2011.

- [28] Schang L, Thomson S, Czypionka T. Explaining differences in stakeholder take up of disease management programmes: a comparative analysis of policy implementation in Austria and Germany. *Health Policy* 2016, <http://dx.doi.org/10.1016/j.healthpol.2016.02.002>
- [29] Krippendorff K. *Content analysis: an introduction to its methodology*, 2e. Thousand Oaks, CA: Sage; 2004.
- [30] Department of Health and Children. *National primary care steering group progress report*. Dublin: Department of Health and Children; 2004.
- [31] Smith S. *Equity in health care: a view from the Irish health care system*. Adelaide: Adelaide Hospital Society; 2009. Available at: <https://www.esri.ie/pubs/BKMNEXT136.pdf>
- [32] Burke S. *Addressing the health care crisis, Congress Briefing Paper No. 10*, Dublin: Irish Congress of Trade Unions; 2007.
- [33] Houghton F. Hiding the evidence : the State and spatial inequalities in health in Ireland. *Irish Geography* 2007; 38:96-106.
- [34] Layte R, Morgenroth E, Normand C, O'Reilly J, Thomas S, Tilson L, et al. *Projecting the Impact of Demographic Change on the Demand for and Delivery of Health care in Ireland*. Dublin: Economic and Social Research Institute; 2009.
- [35] Burke S, Pentony S. *Eliminating health inequalities: a matter of life and death*. Dublin: Tasc; 2011.
- [36] Kringos D. Europe's strong primary care systems are linked to better population health but also to higher spending. *Health Affairs* 2013; 32:686-94.