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Common Histories and Common Failures: How the Historical Events of Ireland and The United States Have Led to their Vastly Different, Equally Failing, Health Care Systems

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COMMON HISTORIES AND COMMON FAILURES:
HOW THE HISTORICAL EVENTS OF IRELAND AND THE UNITED STATES
HAVE LED TO THEIR VASTLY DIFFERENT, EQUALLY FAILING,
HEALTH CARE SYSTEMS

By

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ABSTRACT

The United States healthcare system is a constant source of debate and public interest, with the only common ground between political parties being that the current system is deeply flawed and needing improvement. Individuals often point to European single-payer systems as the answer, neglecting to mention the flaws also inherent in these systems. This thesis aims to suss out the successes and failings of the Irish and American healthcare systems through a thorough scholarly literature review, with an emphasis on the two countries' origins and development, to lead to a discussion about why two countries with similar historical beginnings have created two vastly different, failing healthcare systems. While the United States focuses on freedom of choice and the importance of a free-market, the Irish prioritize equality above all else and yet fail to deliver equal care. This, in conjunction with the scientific discoveries that occurred in the 150 years between the countries' inceptions, and Ireland's proximity to the world wars, has led to their differing approaches to healthcare. Their modern systems are both heavily flawed and in desperate need of improvement. Through comparing their specific failures and current proposals, this thesis aims to discover errors that led each plan astray, in order to suggest future improvements that will genuinely benefit the citizens of each country.

INTRODUCTION

This thesis aims to compare the healthcare systems of Ireland and the United States with a historical context, to lead to a discussion about why two countries with similar historical beginnings have developed two vastly different, failing healthcare systems. The Republic of Ireland and the United States of America were born through over-throwing the British Empire, leading both countries to have fierce patriotism, embracing their freedom. However, the American and Irish experiences under British rule differ, leading to different priorities when forming their respective founding documents. These differences are clearly visible when one compares the Declaration of Independence and the US Constitution to the Easter 1916 Proclamation of an Irish Republic and the Irish Constitution. Additionally, it is important to acknowledge all of the historical events and scientific advances that occurred in the 150 years between the countries' creations, which broadened the understanding of disease, highlighted inequalities, and began creating a more interconnected world.

The American healthcare system revolves around the private market, which allows for economic inequalities to translate into healthcare inequalities, and without proper regulation has become a vastly complex cash-cow, while the Irish have a national healthcare system, in which all citizens receive insurance through the government with limited out-of-pocket expenses. This national system is riddled by a lack of funding, leading to a scarcity of resources and long waiting lists, and the equality of the system is undermined by the public's ability to purchase additional private insurance which allows those with private insurance to cut in line for treatments before those in most need. Both systems are in desperate need for reform, and political parties are lobbying for their preferred solutions, but it is important to understand the immense complexity and scope

of the systems and the cultural beliefs imbedded in the systems before attempting to reform these systems. Through a thorough study of the two systems, it is hoped one can learn from both countries' mistakes and forge a successful and equitable path forward.

HISTORICAL BEGININGS

At first glance, the Republic of Ireland's and The United States of America's historical beginnings are easily relatable; both countries were filled with young scrappy revolutionaries that overthrew the monolithic British Empire. This clear similarity being said, there are some obvious differences between the two revolutions, such as their proximity to England and how long they had been subjected to British rule, that influence the differences in their founding documents. These founding documents give insights to the ideals and priorities of each country, and they ultimately direct how the countries form and manage healthcare systems.

Defining even when British rule began over Ireland is difficult, owing to the power struggles between the Celts, Normans, and Tudors. While Ireland was always a known entity to Europeans in power, North America lived on untouched, with its native people undisturbed until Christopher Columbus's discovery of a new world in 1492. The British colonies were not successfully established until Jamestown, Virginia was founded in 1607, followed by the establishment of Plymouth in 1620 (Luscombe, 13 Colonies). Across the Atlantic, the indigenous people of Ireland were almost constantly exposed to conquerors. In 1169, the Normans were invited to help settle a domestic dispute in Ireland and saw the request as an opportunity to start accumulating land and power on the island (Luscombe, Ireland). As England became more powerful globally, they also gained more direct and supreme power over Ireland, culminating in King Henry the VIII declaring himself the King of Ireland in 1541 (Luscombe, Ireland). The British Crown's rule over Ireland was tumultuous. The Crown viewed the strong ties to the Catholic Church in Ireland as a threat, leading them to try to "pacify" and "secure" [the] territory in Ireland", but this attempt inflamed "more resistance and resentment" within the native

Irishmen and women (Luscombe, Ireland). The Irish led seven armed rebellions in an attempt to assert their sovereignty between the beginning of English rule and the Easter 1916 Proclamation, but they did not succeed in achieving independence until 1921 and the passage of the Anglo-Irish Treaty (Easter 1916 Proclamation, 2010) (Luscombe, Ireland). It took over 700 years for Ireland to free themselves from the British Crown while, marked by the surrender at Yorktown in 1781, the American colonies were subject to British rule for 174 years (Keough-Naughton Institute, 2016) (Luscombe, 13 Colonies). Although they were territories of England, the American Colonies were more able to self-govern due simply to their physical distance from England. When King George III became wary of the powers the colonies self-wielded because of their distance, he began imposing stricter regulations and martial law, resembling the measures the Irish were constantly subjected to. These restrictions in turn magnified the colonists clamoring for independence, converted loyalists, and the call for independence became deafening.

The rebels in both countries capitalized on ambiguous tragedy to rally the public behind their cause and ignite the revolution. Famously, Captain Thomas Preston led eight of his men to fire a volley of shots into a Bostonian crowd, killing five on March 5, 1770 (History.com Staff, 2009). This act was “promptly termed a ‘massacre’ by Patriot leaders and commemorated in a widely circulated engraving by Paul Revere, [arousing] intense public protests and threats of violent retaliation” (History.com Staff, 2009). The patriots conveniently did not acknowledge that this ‘massacre’ was instigated by the rowdy colonial crowd harassing a sentry, denying any culpability on the part of the colonists (History.com Staff, 2009). Similarly, revolutionaries in Ireland were labeled as martyrs

when the fifteen leaders of the 1916 Easter Rising were executed by the British, framing the execution as inexplicable, when this is not quite true (Trueman, 2015). The leaders were frustrated with their protests against home-rule falling on deaf ears, rejecting “that London had any right to impose any rule on Ireland” and argued that since “the British would be unwilling to simply go along with this, such independence would have to be fought for” (Trueman, 2015). While their complaints of being second-class citizens in the United Kingdom were just, they were not in the majority, and their military take-over of buildings around Dublin and proclamation of an Irish Republic was a massive insurrection that led to the death of 450 individuals (Dorney, 2011). This loss of life, along with the 2,000 wounded and the destruction of the General Post Office, was framed to be entirely the British’s fault and used to ignite revolution, which was further fueled when the leaders were executed (Dorney, 2011). Both American and Irish revolutionaries capitalized on and framed tragedies to further their call for independence and this strategy paid off in dividends, rallying the public to their side.

The Declaration of Independence and the Easter 1916 Proclamation of an Irish Republic call upon similar themes, such as the necessity of revolution, the violation of human rights, and the godliness of their cause, but they were not mirror images of each other. While many revolutionaries saw Thomas Jefferson’s eloquently crafted declaration and flirted with plagiarism when adapting it to their own cause, the Proclamation of an Irish Republic is a short and fiery document, crafted not to convince foreign dignitaries and the upper-echelon of society to support the war, but rather to call their fellow countrymen to arms. The Easter 1916 Proclamation begins, “IRISHMEN AND IRISHWOMEN”, literally shouting out to fellow compatriots to join them, while the

Declaration of Independence states, “The unanimous Declaration of the thirteen united States of America”, implying to readers that it is already a united, independent, state (Easter 1916 Proclamation, 2010) (America’s Founding Documents, 2016).

Their intended audiences and tone differ, yet both documents call upon the common theme of “unalienable rights”, stating that when a ruler violates these rights, revolution is necessary and inevitable (America’s Founding Documents, 2016). The Declaration of Independence famously states,

“We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights... Whenever any form of Government becomes destructive of these ends, it is the Right of the People to alter or to abolish it, and to institute a new Government... as to them shall seem most likely to effect their Safety and Happiness” (America’s Founding Documents, 2016).

The Easter 1916 Proclamation uses the same logic to explicitly declare Irish independence, writing,

“We declare the right of the people of Ireland to the ownership of Ireland and to the unfettered control of Irish destinies, to be sovereign and indefeasible. The long usurpation of that right by a foreign people and government has not extinguished the right... We hereby proclaim the Irish Republic as a Sovereign Independent State, and we pledge our lives and the lives of our comrades in arms to the cause of its freedom, of its welfare, and of its exaltation among the nations” (Easter 1916 Proclamation, 2010).

The Declaration of Independence ends with the same sentiment, but it takes Jefferson several pages to build up to this statement that the Irish revolutionaries state in their third paragraph. Jefferson states,

“We, therefore... declare, That these United Colonies are, and of Right out to be Free and Independent States; that they are Absolved from all Allegiance to the British Crown... and that as Free and Independent States, they have full Power... to do all... Acts and Things which Independent States may of right do. And for the support of this Declaration... we mutually pledge to each other our Lives our Fortunes and our sacred Honor” (America’s Founding Documents, 2016).

Jefferson painstakingly builds an argument with documented cases of abuses to justify their independence, while the Irish skip the evidence, assuming the reader is already aware of their circumstances, and immediately declare their independence from Britain and their willingness to bear arms for this cause.

Jefferson also carefully avoids specifying what rights are “unalienable”, writing, “that among these are Life, Liberty and the pursuit of Happiness” (America’s Founding Documents, 2016). This lack of specificity can be interpreted as a political calculation to avoid debate about whether “all men” includes women and people of color, seeing as many privileges were afforded exclusively to white men (America’s Founding Documents, 2016). The Easter 1916 Proclamation of an Irish Republic, however, does not shy away from specifying its call for equality, stating,

“The Irish Republic is entitled to, and hereby claims, the allegiance, of every Irishman and Irishwoman. The Republic guarantees religious and civil liberty, equal rights, and equal opportunities to all of its citizens, and declares its resolve

to pursue the happiness and prosperity of the whole nation and all of its parts, cherishing all of the children of the nation equally” (Easter 1916 Proclamation, 2010).

The proclamation explicitly states and focuses on ensuring equality for each of their citizens, and does not shy away from insisting the diversity of its citizens does not negate their equality under the eyes of the state.

Rather than focusing on the British Empire’s disenfranchisement of their rights, the colonial revolutionaries focus on their ruler’s inability to allow them to self-govern, and the monarchy’s lack of knowledge as to what is best for the colonies. The list of grievances against King George III include,

“He has forbidden his Governors to pass Laws of immediate and pressing importance unless suspended in their operation till his Assent should be obtained”, “He has combined with other to subject us to a jurisdiction foreign to our constitution, and unacknowledged by our laws”, “For imposing taxes on us without our Consent”, “For taking away our Charters, abolishing our most valuable Laws, and altering fundamentally the Forms of our Government”, and “For suspending our own Legislatures, and declaring themselves invested with power to legislate for us in all cases whatsoever” (America’s Founding Documents, 2016).

While the Irish desire independence in order to insure the rights of their people, the colonists are focused on independence in order to determine their collective destiny. The Declaration of Independence’s focus on lack of self-determination, as compared to The Easter 1916 Proclamation of an Irish Republic’s focus on the lack of equality under the

law, may originate from their differing distances from England and lengths of British rule over the territories. Following the list of grievances, the Declaration states, “In every stage of these Oppressions We have Petitioned for Redress in the most humble terms: Our repeated Petitions have been answered only by repeated injury” (America’s Founding Documents, 2016). The very first document of America alludes to the country’s distrust of monolithic government, and its lack of faith in distant government to make appropriate choices for its citizens, stating “They too have been deaf to the voice of justice and of consanguinity” (America’s Founding Documents, 2016). This general distrust of government, and the faith in one’s ability to make the best decision for his or her self, remains thoroughly engrained in American politics, laws, and psyche to this day.

Once Ireland and the United States were granted independence, they attempted to transcribe the ideals that fueled their revolutions into governments through their constitutions. On a large scale, the constitutions and governments established by the two countries are quite similar. Both Ireland and the United States have three nearly identical branches of government which have similar general powers, such as the legislative branch’s ability to levy taxes and create laws, the executive’s ability to maintain the army, and judicial oversight (America’s Founding Documents, 2016) (Bambury & Lantry, 2010). While the general composition and roles of the government created through the countries’ founding documents are similar, the focuses of their constitutions diverge.

The preamble of the Constitution of Ireland mirrors the preamble of the United States Constitution, but, just like the Easter 1916 Proclamation, it focuses more explicitly on equality. The Constitution of the United States opens,

“We the people of the United States, in order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessing of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America” (America’s Founding Documents, 2016).

The preamble of the Irish constitution hits on similar notes of “promot[ing] the general Welfare”, “establish[ing] Justice”, and “secur[ing] the Blessing of Liberty”, but expands on each point, stating,

“We, the people of Éire... seeking to promote the common good with due observance to Prudence, Justice and Charity, so that the dignity and freedom of the individual may be assured, true social order attained, the unity of our country restored, and concord established with other nations, Do hereby adopt, enact, and give to ourselves this Constitution” (America’s Founding Documents, 2016) (Bambury & Lantry, 2010).

While the framers of the US Constitution do seek “to promote the common good”, they do not tie their promotion to “due observance of Prudence, Justice and Charity”, nor do they mention the concepts of selfless giving or cautious judgement (America’s Founding Documents, 2016) (Bambury & Lantry, 2010). This inclusion of prudence and charity may call upon Ireland’s intricate ties to the Catholic church. The first line of their constitution is “In the name of the Most Holy Trinity, from Whom is all authority and to Whom, as our final end all actions both of men and States must be referred”, and prudence, justice, and charity mirror elements of the seven gifts and twelve fruits of the Holy Spirit (Bambury & Lantry, 2010) (Catechism of the Catholic Church, 2000, para.

1830 – 1832). While both countries acknowledge a freedom of religion in the First Amendment and article 44, there are religious themes present throughout the Irish Constitution (America’s Founding Documents, 2016) (Bambury & Lantry, 2010). Most notably, in the preamble the Irish framers state, “the dignity and freedom of the individual may be assured”, refining the American version of “securing the Blessings of Liberty” to include dignity, calling upon the Catholic teaching of the dignity of the human person (Bambury & Lantry, 2010) (America’s Founding Documents, 2016). This teaching is defined in the catechism as “Every human person, created in the image of God, has the natural right to be recognized as a free and responsible being. All owe each other this duty of respect.... This right must be recognized and protected by civil authority” (Catechism of the Catholic Church, 2000, para. 1738) (Feely, 2006). This theme is reiterated in Article 40, which states, “All citizens shall, as human persons, be held equal before the law”, and the idea of equality because of one’s inherent dignity fuels Ireland’s independence, constitution, and healthcare system (Bambury & Lantry, 2010). Repeatedly the Constitution of Ireland references Catholic teachings to further justify their desire for equality for all citizens, rather than subjugating different classes like they were subjugated when they were under British rule.

The American Revolution was fueled by England’s governmental overreach. The violations committed by the British Crown were recorded as a list of grievances in the Declaration of Independence, and while forming their new nation’s constitution, the framers recalled these abuses in the hopes of preventing them from reoccurring. The Third through Eighth Amendments in the Bill of Rights all try to circumvent governmental abuses that colonies experienced, such as unlawful quartering of soldiers,

unlawful search and seizure, excessive bail, and the need for probable cause, due process, and a jury of peers (America's Founding Documents, 2016). Curiously, while the framers were concerned with government overreach, they also wanted to keep the government distant from the common people. Evidence of these concerns can be seen through the senate selection and the presidential election in Article I, Section III and Article II, Section I of the Constitution (America's Founding Documents, 2016). The Connecticut Compromise created two houses of congress, with the Senate being more powerful and not representative of state population (July 16, 1787) (America's Founding Documents, 2016). Additionally, only a third of the seats in the senate are up for election every election cycle, preventing trending political currents from completely reshaping the Senate's composition from year to year (America's Founding Documents, 2016). Similarly, the president is not elected directly by the people, but rather through the electoral college, intentionally distancing the executive branch from the people (America's Founding Documents, 2016). In contrast, Article 12 of the Irish Constitution states explicitly, "The President shall be elected by direct vote of the people", and Article 27, includes the option of people's referendums, without fear of its citizens having too much influence over the government (Bambury & Lantry, 2010). Additionally, while both the Irish and American Constitutions include that the artifact is "the supreme Law of the Land", through which the government draws all of its power, the Irish Constitution prefaces this claim with an acknowledgement of the power of its people, stating,

"All powers of government, legislative, executive and judicial, derive, under God, from the people, whose right it is to designate the rulers of the State and, in final appeal, to decide all questions of national policy, according to the requirements of

the common good” (America’s Founding Documents, 2016) (Bambury & Lantry, 2010).

Instead of fully committing to a democratic state, The United States Constitution juxtaposes the framer’s desire to form a government free from overreach, with a government not crippled by the voice of the uninformed public.

While neither constitution dictates any policy regarding healthcare, the opposing sentiments in the US Constitution leads to a lack of clarity when one attempts to ascertain the founding father’s views on healthcare policy. When when analyzing the Irish Constitution, on the other hand, there is a clear logical progression to universal, single-payer, healthcare. For instance, Article 42 of the Irish Constitution guarantees a free public education system for its citizens, similar to their free public option for healthcare, and Article 45 states, “The State shall favour and, when necessary, supplement private initiatives and commerce” (Bambury & Lantry, 2010). While Americans are concerned with the government interfering with the free-market, the Irish explicitly allow it in their by-laws. In the American Constitution, it is unclear whether or not the federal government is compelled to form a state-funded healthcare system, or if it is a federal overreach. Article I Section 8 specifies that congress has the power to make all laws regarding any federal department, which includes the Department of Health, however, the Tenth Amendment states, “The powers not delegated to the United States by the Constitution nor prohibited by it to the States, are reserved to the States respectively”, and there is no mention of specific powers regarding health or healthcare in the Constitution, which in essence, leaves health and healthcare policy to the states (America’s Founding Documents, 2016). That being said, the 14th Amendment states,

“No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws” (America’s Founding Documents, 2016).

While this Amendment was written with newly freed African Americans in mind, the rights have been extended to other disenfranchised groups such as women and the disabled, so it could be extended to covering those in poverty and with low incomes who are unable to afford insurance. Depriving an individual of healthcare on the basis of income may very well deprive them of “life” (America’s Founding Documents, 2016).

The Irish and American struggles for independence were superficially similar, leading to superficially similar governments, however, when analyzing the context of the revolutions and the focus of the countries’ founding documents, it is clear that the basic interests of the two countries diverge because of their individual experiences under British rule. These divergences lead to the countries different, failing, healthcare systems.

EARLY HEALTH CARE SYSTEMS

While Ireland's and the United States of America's diverging experiences under British rule contribute to their diverging founding documents and healthcare systems, it should also be noted that the understanding of medicine, disease, and society's role in healthcare grew exponentially in the 150 years between the countries' births.

At the time of the American Revolution and writing and passage of the United States Constitution, medicine was viewed as a "family affair", with women caring for the ill in the family, and doctors being summoned exclusively for "very serious, life-threatening illness", and the credentials and training of said doctors was not nearly as in-depth (Fillmore, 2009). In fact, the first medical school in America was established a mere 11 years before the Declaration of Independence at the University of Pennsylvania (Fillmore, 2009). While medicine had moved beyond viewing disease as Godly punishment by at the time of the American Revolution, there still was not a unifying theory regarding disease, with several theories circulating, from Hippocrates' theory of 4 Humors, to Boerhaave's focus on acidity and alkalinity, to Cullen's theory of excess causing disease (The History of Medicine, 2013). This lack of consensus regarding disease, along with the lack of professionalism of the medical field, led to an American healthcare system being essentially non-existent at the time of the Constitution. New York City Board of Health, the first government health department, was not even formed until nearly a century later in 1866 (Public Health Timeline, 2017). Hospitals, which were charitably, not federally, funded, were just starting to emerge in the 18th century (Public Health Timeline, 2017).

One of the largest events that facilitated social change and advocacy for government programming in the time between the signing of the Constitution of the

United States of America in 1787 and the passage of the Irish Constitution in 1937 was the Industrial Revolution. Edwin Chadwick published “The Sanitary Condition of the Labouring Population of Great Britain” in 1842, which was then followed by Friedrich Engles’ “The Condition of the Working Class in England” in 1845 (Public Health Timeline, 2017). This description of urban areas being unable to protect their inhabitants sanitarily, the implication of sanitation on the public’s health, and “a scathing critique of the Industrial Revolution’s effect on the lives of wage laborers” were not limited to those in England, with the Industrial Revolution extending both to Ireland and America (Public Health Timeline, 2017). In Great Britain these conditions led to the passing the Public Health Act in 1848, which established a General Board of Health (Public Health Timeline, 2017). The conditions in America during the Industrial Revolution were equally horrid, and were the catalyst for the progressive movement, the root of modern liberalism. William D. Haywood proclaimed that “with drops of blood the history of the industrial workers of the world [have] been written” (Schambra & West, 2007) (Industrial Workers of the World, 1919). These conditions were generating new political dogma, promoting socialism over capitalism, and this argument gained an international platform through the publication of Karl Marx’s *Communist Manifesto* in 1848 (Marx & Engles, 1848). The ideology of promoting societal good and the government’s role in insuring certain standards of living originated from the horrid conditions of the Industrial Revolution, and echoes of this call are heard to this day.

Historically coupled with the Industrial Revolution, the foundations of public health, epidemiology, and the modern understanding of diseases were gathering momentum on both sides of the Atlantic in the second half of the 19th Century. John

Snow kick-started these scientific discoveries and medical advances by tracking a cholera outbreak in London to the Broad Street water pump and essentially ending the outbreak by simply removing the water pump handle in 1854 (Public Health Timeline, 2017). Louis Pasteur followed this tracing of disease with germ theory, presenting “On the Extension of the Germ Theory to the Etiology of Certain Common Diseases” in 1880 to the French Academy of Science (Pasteur, 1880). Robert Koch then continued the ideas set forth by Pasteur, “devising a universal method for testing whether a specific bacterium causes particular disease, known as ‘Koch’s postulate’”, and was honored for his contributions to bacteriology in 1905, receiving the Nobel Prize in Physiology or Medicine (Hodkinson, 2015). The scientific milestones in the latter half of the 19th century transformed the world into having a modern understanding of disease, and allowed for all of the medical progress that was made during the 20th Century, dramatically improving the human lifespan and quality of life.

The Irish had a similar time line to America regarding early healthcare, with their first charitable hospitals being founded in the 1720’s, but they remained under British rule, following England’s footsteps during the Industrial Revolution and the formation of modern public health standards (Corbett, 2015). World War I triggered a rise in inflation, impacting the donations supporting charitable hospitals, leading to the British government stepping in and providing public funds, taking the preliminary steps towards the formation of their National Health Service (Corbett, 2015). During the transition to their modern independent state Ireland continued the public funding of its hospitals by establishing the Irish Hospitals Sweepstakes in the 1930s, during the transition to their modern independent state (Corbett, 2015). The Irish Hospitals Sweepstakes utilized a

horse-racing based lottery system to fund construction and expansion of county hospitals, augmenting voluntary donations (Irish Hospital Sweepstakes). This fund proved its effectiveness, allocating 13.5 million pounds to hospitals in the first decade of its founding, but it lowered the priority of health funding, which may explain why healthcare was not explicitly mentioned in the Irish Constitution, which was passed in 1937 (Irish Hospital Sweepstakes) (Corbett, 2015). This murky funding source and lack of prioritization foreshadows the modern issues in the state of Irish healthcare.

World War I also effected the United States' healthcare, but, once again the United States was blessed by a lack of proximity to Europe, allowing individuals to be more strategic and opportunistic. While England, and by proxy Ireland, was forced to step in and start federally funding hospitals due to the rising inflation, American hospitals saw a profitable opportunity. "An official at Baylor University Hospital in Dallas noticed that Americans, on average, were spending more on cosmetics than on medical care" in 1929, so Baylor Hospital searched for a way to implement a system in which customers paid a little each month to accrue more capital (Blumberg & Davidson, 2009). "They offered a plan for the teachers to pay 50 cents each month in exchange for Baylor picking up the tab on hospital visits. When the Great Depression hit, almost every hospital in the country saw its patient load disappear. The Baylor idea became hugely popular. It eventually got a name: Blue Cross" (Blumberg & Davidson, 2009). America also felt the rising inflation inherent in war to a lesser extent, but Baylor's system helped keep their doors open, and the subsequent Great Depression solidified the formation of profit driven insurance companies.

The massive casualties during World War I led to research and medical advances for both the Allies and Central Powers in an effort to staunch the death toll (Was World War I, 2014). America, distant from the front lines and a late-comer to the war, saw the need for medical advances and the beneficial by-products from the war, such as the systematic medical records for American soldiers, and could capitalize on these scientific needs without being fully embroiled in the war (Was World War I, 2014). Seeing the importance of medical research, the Ransdell Act was passed in 1930, forming the National Institute of Health and “authorized the establishment of fellowships for research into basic biological and medical problems” (WWI and the Ransdell Act of 1930). While they did not begin funding healthcare like other countries were driven to do at the time, the American Government began publicly funding medical research. To this day America is known for its medical innovations funded through the NIH. The profit motive and research that emerged in the early 20th century with the help of the first World War is still very visible in the modern landscape of American healthcare.

The urbanization and scientific breakthroughs that occurred in the 150 years between the writing of the American and Irish Constitutions triggered some change and development in the American healthcare system, but the contradictions and the framers’ purposeful ambiguity in the US Constitution left little guidance on how to handle these changes, while Britain clearly led Ireland through this transition.

CURRENT HEALTH CARE SYSTEMS

As alluded to throughout this paper, the current Irish and American healthcare systems are vastly different, but still are equally plagued with problems. Before attempting to understand the intricacies of both systems, it is important to understand the three broad categories of systems that countries fall under, and how Ireland and the United States fit into these categories. First there is the private insurance model, which is “defined by the absence of state involvement in the provision of service” (Brady, 2010). Instead of state involvement in healthcare, the private insurance model trusts the free market to provide the best level of care through competition (Brady, 2010). There is also the social insurance model, which offers universal coverage through “mandating that all residents obtain health insurance” which is funded by both the government and individual contributions depending on income level (Brady, 2010) (Bidgood, 2013). Lastly, there is the national health service model in which universal coverage is funded through general taxation, making healthcare “often free at the point of use” (Brady, 2010). The Irish healthcare system follows primarily a national health service model, but it does allow individuals to subsidize this universal insurance through purchasing private plans. The American system, in contrast, relies almost entirely on the private insurance model, but with the individual mandate through the Affordable Care Act, has taken preliminary steps towards a social insurance model.

To understand America’s insurance and healthcare system, it is important to first understand how insurance providers generally operate. Insurance companies pool money together from all of their different clients’ healthcare premiums to create a risk-sharing pool, so that they can cover occasional large expenses while still making a profit (Brookings Institution, 2014). In order to drive expenses even lower, insurance

companies negotiate prices with doctors, hospitals, and pharmaceuticals, and through these negotiations create in- and out-of-network entities, offering only to cover in-network expenses to motivate their insured population to only use those entities that they have been able to successfully negotiate with (Brookings Institution, 2014). This obviously can create a lot of fluctuations in pricing depending on which insurance company one has and where one is, because if there is only one hospital in a rural area, there is no competition to drive negotiation, while if one is in New York City, where hospitals abound, the competition breeds negotiation (Brookings Institution, 2014). Additionally, the American healthcare system is built around a fee-for-service model, in which a price is assigned each good or service associated with one's medical care, which are then all billed to the patient or his or her insurance company (Brookings Institution, 2014). Hospitals know that insurance companies will negotiate and bundle prices, so they list outrageous prices for each service, which they are then negotiated down from. However, if one is uninsured, he or she is left with an astronomical bill that they are unable to negotiate, explaining why "health care costs are the #1 cause of bankruptcy in this country" (Brookings Institution, 2014) (Amadeo, 2017).

Americans can be divided into four groups when looking at health insurance coverage: those who pay directly for insurance, those whose employers pay their premiums, those whose medical care is paid for by the government, and those who must directly pay providers for treatments because they are uninsured (Brookings Institution, 2014). Approximately half of Americans receive health insurance through their employers (Brookings Institution, 2014). Employers cover the expense of their employees' premiums as an incentive to attract the best potential employees, but there is

the additional preventative care benefit that employees who visit doctors before something cataclysmic occurs protect the company's bottom line (Brookings Institution, 2014). Additionally, the value of one's premium is not taxed, unlike one's salary, so insurance has a higher intrinsic value than one's paycheck, incentivizing employees to want their employer to cover their insurance (Brookings Institution, 2014). The government provides health insurance to roughly a third of the population through financing Medicare and Medicaid, which will be further discussed later (Brookings Institution, 2014). A small sliver of the population pays premiums directly to insurance companies (Brookings Institution, 2014). These individuals are often self-employed or their employer does not cover health insurance, but they have the means to afford the premium on their own (Brookings Institution, 2014). The remaining Americans, approximately 32 to 52 million people, were uninsured before the implementation of the Affordable Care Act, colloquially known as Obamacare (Amadeo, 2017). This number varies so much depending on the different criteria one uses to count the uninsured, but it is important to understand that the clear majority of the uninsured have at least one full-time employed family member, but these individuals don't receive healthcare through their job (Brookings Institution, 2014). Despite being employed, one-third of this population makes below the federal poverty level and another third making between 100 percent and 250 percent above the federal poverty level. With these low levels of income, it is nearly impossible to afford insurance's high premiums, so they must go without (Brookings Institution, 2014). In 2010 the Affordable Care Act, ACA, attempted to tackle the issues associated with the uninsured population, the rising cost of Medicaid and

Medicare, and the lack of regulation in the insurance industry, but the bill had mixed results.

The uninsured do not just effect their own bank account when they go to the hospital. Since they are unable to afford their care, they often do not pay the bill, causing the cost of healthcare to rise for everyone as hospitals adjust for this lack of revenue (Amadeo, 2017). The ACA mandates that all Americans are required to have insurance or pay up to a 2.5 percent tax on their income, with a minimum fine of \$625 per adult, but this mandate was coupled with making access to insurance easier (Amadeo, 2017). First, it allowed children to stay on their parent's plan until age 26, while also making it illegal to deny an individual health insurance due to a pre-existing health condition or drop an individual from a plan because they become ill, as well as expanding access to Medicaid by increasing the eligible income to 138 percent of the Federal poverty level nationwide (Amadeo, 2017). Additionally, for those who still make too much to qualify for Medicaid but had an income at or below 400 percent of the poverty level, the ACA offered subsidies and capped out-of-pocket expenses to make obtaining health insurance more affordable and created insurance exchanges on healthcare.gov, so that one can effectively shop for insurance (Amadeo, 2017). Small businesses were also given "a tax credit worth up to 35 percent of [their] contribution to [their] employee's health insurance. Non-profits receive a 25 percent credit" if they offer health insurance to their employees, and companies with more than 50 employees must provide health insurance, with those with one hundred or more employees facing a \$2,000 fine per employee if they fail to do so (Amadeo, 2017). These business mandates are not without controversy; President Barack Obama made an infamous promise during the passage and implementation of the

Affordable Care Act that “if you like your plan, you can keep it, period” (Amadeo, 2017). This promise fell short. Three to five million employees lost their existing plans because employers found it more affordable to pay the penalty rather than paying their employees’ premiums, their plans were non-compliant to the ACA’s new essential benefits, or their employers switched to more affordable plans found through the exchanges (Amadeo, 2017). The mandates are also highly controversial, with many believing that requiring individuals to have insurance is outside of the scope of the federal government, but the mandate was upheld by the Supreme Court in 2015 (Amadeo, 2017). While controversial, the mandate resulted in more healthy people paying premiums and increased access to preventative care, lowering overall healthcare costs for everyone (Amadeo, 2017). The ACA also targets insurance companies’ gluttonous spending, requiring that at least eighty percent of premiums be spent on providing actual medical services rather than advertising or insurance executives’ salaries (Amadeo, 2017). While the Affordable Care Act acted towards lowering the number of uninsured and the cost of insurance, it neglected to tackle hospitals over-charging for services and massive administrative spending, nor did it establish a public option available to all, and its implementation has yielded mixed results.

America lacks a universal public insurance option, but it does have Medicare and Medicaid, two federally-run programs that provide health insurance to the elderly, disabled, and poor. Medicare is completely financed by the federal government, accounting for around 500 billion dollars of the United States’ annual expenditure, and is designed to provide medical care to the elderly, disabled, and those with kidney failure and ALS (Brookings Institution, 2014). Medicare is financed through a 2.9 percent tax

levied on all American wages, half of which is paid by the employer (Brookings Institution, 2014). Medicare is subdivided into four components. Medicare Part A is designed to cover hospital expenses, with individuals required to pay a \$1,000 deductible for the first 60 days of hospitalization and co-insurance after this time (Brookings Institution, 2014). Because Medicare is such a large entity, covering around a sixth of Americans, it is able to negotiate with hospitals and bundle prices better than any private insurance company. Doctor expenses are covered separately through Medicare Part B, which one must enroll in and pay a \$100 a month premium, along with a deductible and co-pay (Brookings Institution, 2014). Doctors receive compensation based on a relative value unit, RVU, assigned to each action a doctor may take, from talking to a patient, to a chest x-ray, to a colonoscopy, and then adding all the RVUs accumulated throughout a visit together and multiplying it by a conversion factor, which is typically \$40 (Brookings Institution, 2014). This system allows Medicare to have national fixed prices, as contrasted to insurance companies constantly negotiating and allocating physicians as in-network and out-of-network (Brookings Institution, 2014). Medicare Part C is a system by which Medicare purchases a private insurance policy for an individual, covering those premiums, and then the private insurers cover the patient's expenses (Brookings Institution, 2014). Medicare Part D was established to cover comprehensive drug benefits, covering the costs of prescriptions, but this program has significantly contributed to the federal debt because the program did not designate taxes to finance the program and Medicare is not allowed to negotiate pharmaceutical prices (Brookings Institution, 2014).

Medicaid, similarly, is the government-run program designed to provide medical services to the impoverished, but the states have more jurisdiction in this program. Rather than the federal government funding the program entirely, the cost of the program is split evenly between the states and federal government, and the states set the qualification requirements for their state (Brookings Institution, 2014). Medicaid is a means-tested program, meaning that one has to prove that they meet a certain level of poverty dictated by having an income below a predetermined percentage of the federal poverty level to receive benefits, and some states are more “restrictive” while others are more “permissive” when determining who meets this qualification (Brookings Institution, 2014). This means depending on a state’s fiscal and political leanings it can be twice as hard to qualify for Medicaid in one state than it is in another state (Brookings Institution, 2014). As mentioned previously, the ACA tried to expand coverage under Medicaid, stating that all Americans making under 133 percent of the federal poverty level, regardless of dependents, qualify for Medicaid, offering to cover 90 percent of the cost of this expansion (Brookings Institution, 2014). The Supreme Court, however, struck down the claim that the federal government could require states to expand Medicaid, so 19 states refused to do so due to philosophical opposition to the bill and fear about how much they would eventually have to pay because of this expansion (Amadeo, 2017). This seriously undercut the ACA’s attempt to insure all Americans, and created a coverage gap between those who qualify for Medicaid and those that can afford private insurance with the government subsidies (Amadeo, 2017). Luckily, those in this gap are exempt from the mandate tax, but they still have to suffer the consequences of being uninsured in America’s expensive, fee-for-service model of healthcare (Amadeo, 2017).

The United States healthcare system is extremely complex, and while regulations have been implemented, there is still copious spending going to the administrators of hospitals and insurance companies rather than medical services. Additionally, there is a lack of regulation of how much healthcare providers can charge for goods and services, and a sizable population of Americans is uninsured even after the passage of the Affordable Care Act. Implementing regulations and reform has proven extremely difficult with lobbyists powerfully arguing against changes so that the concerns they represent can keep their profits. Mobilizing public support for reform in any direction proves extremely difficult when the average American struggles to understand their own medical bills and is content with their coverage.

Ireland's healthcare system is run by the Health Service Executive, HSE, and consists of primary and acute healthcare services. Primary care, which one can colloquially associate with 'check-ups', is provided through general practitioners, GPs, who work independently, similar to the private practices seen in the United States (Bidgood, 2013). The acute healthcare system revolves around hospitals, which are further subdivided into HSE hospitals, voluntary public hospitals, and private hospitals based on funding and patient load (Bidgood, 2013). HSE hospitals are fully owned and funded by the state, while voluntary public hospitals are funded primarily by the government, but are run by private bodies, such as the Catholic Church, and private hospitals are for-profit facilities that are funded through private health insurance (Bidgood, 2013). As of 2011 there were fifty-seven acute hospitals and over 10,600 public hospital beds, but some beds in HSE and voluntary hospitals are allocated to private patients, so not all of their resources are going towards public patients, and while

private patients in public hospitals pay higher rates, their expenses are capped at €750 per year (Bidgood, 2013). Additionally, voluntary hospitals can supplement their government funds and can retain unused funds, while HSE hospitals are required to return any unused funds back to the government, adding increased difficulty to financing (Bidgood, 2013). If a patient's wait time for treatment extends beyond a legally defined period, the government will pay for private treatment, which curtails wait-time and incentivizes quicker delivery of services but further divides the government funding (Bidgood, 2013).

The HSE establishes two categories of public insurance based on age and income, which in turn determines one's benefits. Thirty percent of the Irish are eligible for a Category I medical card, which insures that both acute and primary healthcare will be free at the point of use and issues a €0.50 prescription charge, which is capped at €10 per month (Bidgood, 2013). Everyone over age 70 and low-income individuals under the age of 70 are eligible for this Medical Card, while the remaining seventy percent of the populous falls under Category II (Brady, 2010). Those in Category II are responsible for their own primary care costs, which typically vary between €35 and €80 per visit because GPs are able to set their own fees (Bidgood, 2013). Acute treatments in hospitals are covered, but one must pay a €75 per night bed fee, which is capped annually at €750, and there is a €100 fee for emergency room treatment without a GP referral (Bidgood, 2013). This emergency room fee insures that the GP is the gate-keeper to medical care and aims to limit the number of individuals entering emergency rooms and clogging up hospital systems unnecessarily (Brady, 2010). This reliance on general practitioners is a trend seen in many European countries but conspicuously absent from the American healthcare landscape. Additionally, prescriptions are not subsidized, but there is a cap of €120 worth

of prescription expenses per month (Bidgood, 2013). These additional fees along with the wait times associated with public hospitals draws consumers to the private health insurance market.

It is estimated that fifty percent of Irishmen and women supplement the universal state provided health insurance with private insurance, but this action does not come without issues (Brady, 2010). Elliot Bidgood summarizes the controversy stating,

“Ireland’s somewhat convoluted approach to relying primarily on tax financing and central public administration, but with the two categories of public subsidy and with a substantial share of the population being able to jump queues if they have private insurance, has led to common objections that the health system in Ireland is tiered and inequitable” (Bidgood, 2013).

Those with insurance are able to “jump queues” because public hospitals dedicate beds to both public and private patients, creating a “mix of private and public patients” on different waiting lists for the same procedures, which in turn allows those who are able to afford private insurance to “access specialist care and services ahead of those in most need” (Bidgood, 2013) (Brady, 2010). And of course, those with private insurance have exclusive access to private hospitals.

Additionally, doctors are allowed to both work on salary for the state and on a fee-for-service model for private patients, but there is a lack of regulation dictating how many hours a physician must serve public patients to remain on a government salary (Brady, 2010). “The system incentivizes consultants and organizations to favor private patients” creating a two-tiered “apartheid” of healthcare favoring the rich (Brady, 2010). These disparities are especially evident for the “approximately twenty-seven percent of

the Irish population [who] have neither Category I eligibility nor private health insurance”, which creates a gap of coverage for those who make just above the poverty threshold for Category I coverage but are unable to supplement their Category II coverage with private insurance (Brady, 2010). This is similar to the tragic gap of care made evident during the implementation of the Affordable Care Act where those who aren’t poor enough to meet the Medicaid qualifications but are not rich enough to afford health insurance must go without.

One of the major factors driving the continual reliance on private insurance is Ireland’s scarcity of resources. Ireland’s economy is significantly smaller than other major countries, ranking as the fortieth richest country in terms of gross domestic product in 2015, while the United States, comparatively, ranked first (World Bank.org, 2016). This lack of Irish capital leads to penny-pinching to ensure funding to all essential programs, and the 2008 global economic crisis led to severe reductions in spending (Bidgood, 2013). David Cronin sited that after the Great Recession “Ireland is second only to Greece in terms of scale and speed of health cutbacks undertaken by developed countries” (Cronin, 2013). Scarcity is the driving factor behind the massive waiting lists seen throughout Ireland’s public insurance system. In the middle of 2015, “414,000 people were on the out-patient waiting list, including 85,000 waiting for more than a year” and the number of trolleys, known in the States as hospital gurneys, used by individuals waiting for inpatient beds, “peaked at a record high of 601 on a single day [in January 2016]” (Cullen, 2015). Such wait times are almost non-existent in America, with hospitals being incentivized to see as many patients as possible to accrue more revenue, while the Irish only have the funding to complete a fixed number of procedures. The only

American healthcare landscape where this is seen is the Veterans Administration, which similarly has “overworked physicians, high turnover, and schedulers who are often hiding the extent to which patients are forced to wait for medical care” (Zucchini, 2014).

This scarcity of resources requires the Irish government to reallocate funds, raise taxes, or influence demand, but a high percentage of public funds are already allocated to the HSE and the current political climate makes increasing taxes extremely unpopular, so public officials lean on influencing patient demand (Brady, 2010). The Irish government successfully lowers demand on health services through charging for GP visits, fining those who go to ER without a referral, and creating waiting lists for elective services (Brady, 2010). While these initiatives do lower healthcare expenditures and “inappropriate use of such health services, they also deter necessary use” (Brady, 2010). Demonstrating this deterrence, 18.9 percent of patients in the Republic of Ireland had a medical problem in the previous year, but did not consult a doctor due to cost, as opposed to 1.8 percent of patients in Northern Ireland, which in turn corresponds with disparate morbidity and mortality rates between the two countries (O’Reilly, 2007). “Waiting times and overcrowding... also act as deterrents to using publicly funded services and provide an incentive to opt for private health care” (Brady, 2010). This scarcity of resources will continue to escalate as the population of Ireland “is estimated to rise to 4,900,000 by 2025”, as they have the second highest fertility rate in Europe at 1.88 (Brady, 2010). This not only means that the larger population will increase the demands on the healthcare system, but also that Ireland’s currently young (and fertile) population naturally will age, causing “a significant increase in the ratio of older persons in the population... in the coming decades” (Brady, 2010). In fact, “every year another 25,000 citizens turn 65”

(Cullen, 2015). This growing and aging population will continue to place strain on Ireland's resources, and America's current struggle to afford Medicare and Social Security entitlements with the aging Baby Boomer population may foreshadow the issues Ireland will face in the coming decades. Additionally, healthcare is politically viewed as a "black hole" in Ireland, just as Social Security and Medicare are referred to as the 'third rail' of American politics, making reform extremely difficult in both countries (Brady, 2010).

This lack of resources has also led to a lack of medical professionals in Ireland, with many Irish doctors and nurses immigrating to other countries where they will receive better pay.

"Staff are abandoning the health service for better pay and conditions in Australia, Canada, and the UK. The system is increasingly staffed by temporary and agency workers on short-term contracts, unfamiliar with their working environment, often overeager to order tests, unwilling to make decisions independently. Money is an issue, but what seems to tip many over the edge are the chaos and uncertainty" (Cullen, 2015).

The Nursing and Midwifery Board of Ireland received almost 10,000 applications for Certificates of Current Professional Status, the needed paperwork for Irish nurses to work abroad, between 2010 and 2015, demonstrating the mass exodus of Irish healthcare professionals (Cullen, 2015). Working abroad promises higher wages as well as ridding the "general disrespect" health professionals feel "in Ireland from the media and HSE" (Cullen, 2015). This trend will continue as long as the Irish healthcare system continues to fail both its citizens and its healthcare professionals, with almost ninety percent of

current Irish medical students contemplating leaving Ireland after completing school (Cullen, 2015).

While scarcity of resources is a leading issue in Irish politics, with the HSE claiming it needs an additional €2 billion to “revive” the system, America outspends every other nation on healthcare, without better results (Cullen, 2015). In 2013 the Organization for Economic Co-operation and Development, OECD, reported the average total expenditure on healthcare in thirty-five participating countries was \$3,322 per capita, with Ireland spending \$3,700 per capita, or 8.9 percent of GDP, and America spending the most at \$8,508 per capita, or 17.7 percent of GDP (OECD, 2013). With these health expenditures one would expect Ireland’s healthcare results would be above average and the United States to massively outshine the rest, but sadly neither country has optimal health outcomes. According to the same OECD study Ireland and the United States ranked twenty-second and twenty-sixth in life expectancy, sixteenth and thirty-first in infant mortality rates, twenty-fifth and twenty second in cardiovascular disease death, and twenty-sixth and tenth in all cancer mortality rates, respectively (OECD, 2013). Clearly, simply increasing spending is not the solution for improving healthcare quality and equity. As Paul Cullen states, “Money will be thrown at the system to effect temporary solutions to the problems. And the cycle will repeat itself unless there are radical changes” (Cullen, 2015).

FUTURE FOR HEALTH CARE

Despite the positive strides made by the passage and enactment of the Affordable Care Act, the future of the law and the American healthcare system is anything but clear. A major drawback to the ACA, beyond the philosophical disputes regarding whether the federal government has a role in healthcare and mandating coverage and its budgetary consequences, is the rising cost of premiums, affecting many families across the nation. In 2016 citizens in some areas of the United States were subjected to an average of a twenty-five percent increase in the cost of their premiums, and these premiums continue to climb (Martin, 2017). These increases are attributable to more sick people joining insurance pools, which hasn't been met by the anticipated increase in young, healthy Americans enrolling (Martin, 2017). Additionally, in rural areas there aren't enough providers to compete and drive premium costs lower, and while "8 out of 10 people that enroll in the health insurance exchanges get some kind of help with their premiums or out-of-pocket costs.... There are still 10 million people that... buy health insurance [on the individual market]... [who] don't qualify for the financial assistance" (Martin, 2017). These issues, along with ideological differences, have driven the entire Republican Party to run on the platform of repeal and replacement of Obamacare, and Democratic presidential candidate Senator Bernie Sanders to advocate for a Medicare-for-all single-payer proposal which Secretary Hillary Clinton partially adopted in the general election. The election of President Donald Trump and the Republican Party's current control of all three branches of government makes the path for the American healthcare system even murkier, seeing that the Republicans have spent the past 7 years in constant opposition of the ACA, without mention of their replacement proposal.

Months after his election and inauguration, President Trump and Speaker of the House Paul Ryan unveiled their replacement proposal for the Affordable Care Act, entitled the American Health Care Act, AHCA, also colloquially known as Trumpcare or Ryan care. While the AHCA proposed keeping the massively popular components of the ACA, such as the “prohibition on discriminatory premiums and pre-existing conditions exclusions, [and the] requirement to extend dependent coverage to age 26”, it proposed replacing “income-based tax credits with [a] flat tax credit adjusted for age” (Kaiser Family Foundation, 2017). Additionally, it would repeal the individual mandate and corporate mandate and instead incentivize individuals to obtain insurance by enforcing a late enrollment penalty for those who do not maintain continuous coverage, which is clearly problematic for those who are unexpectedly laid off their jobs, the uninsured, and those whose employers would drop their coverage once they are no longer required to provide insurance (Kaiser Family Foundation, 2017). Representative Lloyd Doggett scathingly attacked this bill stating, “This is not the art of the deal.... It is the art of the steal, of taking away insurance coverage from families that really need it to provide tax breaks for those at the very top” (Pear, 2017). The Democrat from Texas is not wrong; one of the increasingly problematic issues with the AHCA is the Congressional Budget Office estimate that “in 2018, 14 million more people would be uninsured under the legislation than under current law” and that by 2026 “an estimated 52 million people would be uninsured, compared with 28 million who would lack insurance that year under current law” (Congressional Budget Office, 2017).

Due to these damning issues with the bill, along with fiscal concerns, Paul Ryan was forced to pull this legislation from the House floor Friday March 24, 2017, stating

“We’re going to be living with Obamacare for the foreseeable future” (Pear, 2017).

Despite outnumbering the Democrats by 44 seats in the House, Republicans were unable to pass this bill because conservatives “wanted a more thorough eradication of the Affordable Care Act” and moderate Republicans disliked the marked increase in the number of uninsured as estimated by the CBO (Pear, 2017). After this failure President Trump stated, “Obamacare unfortunately will explode. It’s going to have a very bad year.... Democrats will come to us and say ‘Look, let’s get together and get a great healthcare bill or plan that’s really great for the people of our country’” (Pear, 2017). While a president rooting for the healthcare coverage of millions of Americans to fail is disturbing to say the least, there is no indication that the ACA is exploding, so Obamacare and the problems inherent to it are here for the foreseeable future (Martin, 2017).

Moderate Democrats seem satisfied with this status-quo, while the far-left is also fighting for reform, but their counter-proposal is also plagued with issues. Senator Bernie Sanders, the face of the Progressive movement, proposed the expansion of Medicare to cover all Americans, with patients still maintaining the ability to choose their own doctors with this comprehensive care (Medicare-for-All, 2016). Sanders urged, “It is time for our country to join every other major industrialized nation on earth and guarantee healthcare to all citizens as a right, not a privilege” (Medicare-for-All, 2016). Sanders points out, as discussed earlier in this thesis, the cost discrepancy of healthcare expenditures between the United States and other countries, magnified by the lack of results and comprehensive coverage on the domestic front, and his proposal would increase insurance coverage “by an estimated 28.3 million people in 2017” while driving

down individual expenditures for care (Bernie Sanders, 2016) (Holahan, 2016). However, this increase in coverage does not come without a cost, with national health expenditures estimated to increase by 6.6 trillion in the next 10 years, and while “Sanders’s revenue proposals... would raise \$15.3 trillion in revenue over 2017 to 2026, this amount is approximately \$16.6 trillion less than the increased federal cost” (Holahan, 2016).

Ireland is also plagued with implementation issues regarding current health care reform. In 2012 Fine Gael, led by Enda Kenny, ran on a “money-follows-the-patient” model of healthcare, proposing that modifying the Irish system to mirror the Dutch system is the answer for the Irish healthcare system woes (Bidgood, 2013). The Dutch system is a social insurance model of healthcare in which universal healthcare is achieved through mandating coverage and subsidizing insurance for those who qualify financially (Bidgood, 2013). This system allows individuals to choose the coverage they see fit, and promotes competition between different private insurers, with the government providing regulation and consumer information (Bidgood, 2013). The Labour party opposed this proposed abolition of the HSE, and advocated for Ireland to model their insurance after the German system, a pseudo-social insurance model with a public option, but the Irish preferred Edna Kenny’s proposal, and Fine Gael won the election and thus the power to implement change (Bidgood, 2013).

Implementation, as both President Obama and Trump discovered when they assumed office, however, is difficult. Fine Gael has been harshly criticized for failing to fulfill their past campaign promises, and their plans are now being met with strong opposition. The Labour Party argues that “Fine Gael had effective[ly] made a promise on health care five years ago that it ‘hadn’t a clue how to implement’ and once they got into

government they delayed implementing it” (Roche, 2016). They maintain that Fine Gael promised universal free General Practitioner care and now analysts are stating that “it is not even possible in the next five years because you need about 2,000 GPs... to implement it” (Roche, 2016). Additionally, a new rising political power, Fianna Fail, is determined to stall their reforms and the dismantling of the HSE (Rowan, 2016). This political tension intensified in the 2016 Irish General Election. While Enda Kenny and Fine Gael maintained their position in power, they lost 16 seats, at the same time Fianna Fail gained 23 seats. This not only signifies a major shift in party momentum, but also cuts drastically into Fine Gael’s majority, with only 6 more seats than Fianna Fail. This will make further implementation even more difficult, and it brings into question whether there is still a consensus among the Irish that abolishing the HSE and adopting the Dutch model for healthcare is the appropriate path for the Irish going forward.

President Trump, Paul Ryan, and Enda Kenny have all discovered how difficult healthcare reform can be, and that once in office it is much harder to implement their theoretical political talking points. Adding to the complexity of reform is the public’s great desire for improvement without being subjected to personal changes. According to a 2013 Gallup poll, only 23 percent of Americans would rank healthcare coverage in America as good or excellent, while 69 percent would rank their own coverage as good or excellent (Newport, 2013). While the population knows the system needs reform, they are satisfied with their personal care, so they don’t want change in their own coverage, nor are they largely inclined to advocate for this change because of their satisfaction with their personal coverage. Additionally, any healthcare plan has inherent trade-offs that politicians neglect to mention to their constituents while running for election, which, once

exposed in office, become increasingly divisive (Green, 2017). The tendency is to gloss over these trade-offs in public debate where what is needed is rigorous discussion with a plethora of information so that the best option can actually be exposed. The grossly simplistic proposals seen in both Ireland and the United States lead at best to stagnancy once in office and, more likely, reform that is doomed to fail.

CONCLUSION

The failure of the American Health Care Act helps to illustrate how complex the healthcare system is and that one cannot walk in and reform the system without an intimate understanding of it. Additionally, it showcases how desperately Americans want reform, but lack a clear path forward. Similarly, the Irish are lobbying for massive reform, but have failed thus far in actually initiating change. The Affordable Care Act and the proposals put forward by the Fina Gael and the Labour Parties in America and Ireland closer to social insurance models similar to those seen in the Netherlands and Germany. This model may be the solution the healthcare systems of both countries are in so desperate need of, but to implement change that will lead to improvement rather than creating more complexities and healthcare disparities, one must enact well-thought-out reform, which understands both the complexity of the nation's systems and the cultures unique to each country.

The United States, for instance, passionately defends individualism and one's right to choose for him or herself what plan is best suited for them, which was deeply engrained by their resentment and eventual overthrow of the British monarchy for not understanding the unique issues facing the colonies and being denied the ability to self-govern. This distrust of government and deep desire for freedom has transformed itself into a glutinous and complex health care system that is nearly impossible to understand and even harder to regulate. Meanwhile, the Irish were relegated to second class citizens under British rule for an extensive amount of time, making them value equality above all else, but they have managed to create a healthcare system that has the false appearance of equality yet is constantly undermined by the presence of private insurers, and further exacerbated by Ireland's lack of capital.

There are no easy answers for reform, only the imperative that reform is clearly necessary if these countries want to continue to grow and thrive.

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