Health Care and Neoliberalism in Ireland:

Withholding the Gift and Corrupting the Social Contract

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A critique is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kind of assumptions, what kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest.

- MICHEL FOUCAULT

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Declaration

I declare that this thesis is my own work and has not been submitted for another degree, either at University College Cork or elsewhere.

Angela V. Flynn

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Abstract

The health of a nation tells much about the nature of a social contract between citizen and state. The way that health care is organised, and the degree to which it is equitably accessible, constitutes a manifestation of the effects of moments and events in that country's history.

Using four case studies, this thesis uses a historical genealogical approach to explain the evolution of Ireland's particular version of health care provision. The total social fact of the gift relationship, central to all human relations, will be used to form a theoretical and conceptual framework on which to build an analysis of Ireland's health and welfare conditions. Additionally, social contract theory will enable an examination of the role of solidarity in relation to social expectations around health care provision.

Through the analysis of these cases, the complex matrix of the influential forces that have shaped current conditions are exposed and revealed, enabling a critical understanding of the extent of acquiescence to the inequitable system that arguably exists. The vulnerability of citizens in need of care to the external and global effects of market forces and neoliberalism, therefore, becomes central to any argument for state-provided health and welfare.

The hegemony of such forces can be seen to influence the manner in which the idea of individual self-reliance, in place of collective solidarity, is conceptualised and subsequently infiltrated into a range of aspects of the social world. For example, the particular discourse of the market and of economic concerns succeeds in shaping understandings of responsibilities around central areas of health and welfare. Similarly the 'possessor principle' can be seen to be misplaced within the context of health and social care, but yet has become normalised within this discourse. Within this matrix of complex influencing factors, the welfare state struggles to impose a balance between market values and social values. Responsibilities of the state to support and compensate its citizens for the ills of the market have become devalued,

as the core values of classical liberalism have become distorted beyond recognition, leaving instead bare neoliberal concerns.

This thesis traces the genealogical origins of this transition within the recent history of Irish health care and thereby reveals the embedding of individualism in place of solidarity, the on going reneging of the social contract and the corruption of the gift relationship.

Chapter 1: Introduction

Introduction

The purpose of this thesis is to challenge what we have taken for granted in Ireland's health care system, and to stand back, so as to look at it from a philosophical perspective that considers the social contract, solidarity and the notion of the gift relationship as substantial, socially supporting structures. This thesis will ask, therefore, what is meant by a social contract, and aims to determine instances where a social contract could more accurately be described as a market contract. Furthermore, this research will seek to establish how organic solidarity features in a world where the human subject has been transformed into merely an actor in a market. Primarily, this research will seek to examine and establish the process in which gross inequalities and injustices in health and welfare arrangements have become normalised and legitimated so as to fail to raise substantial challenge.

Solidarity, a concept that has received much theoretical analysis, can be best understood as an innate human instinct to act in support of fellow beings. This thesis will argue that this instinct has been significantly eroded by neoliberalism to the point of rendering compassionate communitarianism an atypical, peculiar human feature. There are empirical sites where this can be examined, but a country's health and welfare regime is a crucial locus of the manifestations of such core principles. Furthermore, health and welfare arrangements reflect the state's preparedness to intervene to support its citizens in times of vulnerability, as well as the public's preparedness to tolerate inadequacies in such a system.

This thesis though, is not merely about Ireland's health care system. Instead it offers a broader socio-political history of Ireland, and, further than that, this thesis looks at an earlier philosophical, historical, cultural and sociological formulation of the problems faced in Ireland's health system and welfare state. As a result, this research speaks to other aspects of the social world in Ireland, so that we may extrapolate beyond Ireland's health system to its housing system, or its education system, for example. All of these aspects of human necessities are increasingly seen as sites for the involvement of competition and the market. Once within this domain

of the marketplace, an entirely different environment is created from that of the social protectionist approach of true welfare state arrangements. The welfare state therefore, has struggled to survive in the face of neoliberal challenges. Consideration of the individual has become increasingly superior to a communal, or societal perspective and, furthermore, each individual, with their inviolable 'freedom to choose', is bombarded by choices. As the power and hegemony of neoliberalism become increasingly obvious in Irish social policies and in Irish health care, it is increasingly relevant to question how the discourse of 'choice' and individualism has contributed to the unequal and unjust conditions for recipients of health and welfare in Ireland today. This thesis aims, therefore, to examine how such discourse has, paradoxically, limited freedoms, as well as succeeded in muting the capacity to critique the inadequacies of their circumstances and to raise reasonable objections. Such conditions have been moulded by events and contingencies laid down in history and so for this reason a historical perspective is most appropriate in order to trace their origins.

Aims and Objectives

This thesis aims to trace the genealogical origins of transition in the history of Irish health care to contemporary conditions of inequality within health and welfare. The research will thus reveal the challenge to solidarity in the context of an increasingly individualistic field, as well as the on going reneging of the social contract through the corruption of the gift relationship. In order to meet these aims, a series of carefully selected illustrative case studies will be used that exemplify key transformative moments that have contributed to the legitimation and normalisation of inequitable conditions. Each of the case studies will be treated as a genealogy and examined using a method informed by the work of Foucault (1969). In particular, the manner in which subsequent discourses become altered, and consequently provide changed conditions for interpretations and understandings thereafter, is a focus of this thesis. In summary this research will uncover the origins of societal acquiescence to an unequal health system and will examine the inherent implications of this acquiescence for the social contract and for social solidarity.

This introductory chapter begins with a descriptive section that outlines the evolution of the Irish health service. The following section presents a comprehensive overview of the substantial body of empirical evidence of persistent health inequalities, as well as the significant body of knowledge that surrounds the social determinants of health. These sources of evidence are gathered from international research demonstrating that such inequalities are found on global, European and national levels. Having established the deeply inequitable and socially relevant determinants of health as a foundation for the thesis, this chapter will then go on to introduce the structure of the thesis and the systematic approach that has been taken to the research therein. A final section will provide the rationale for the methodological approach taken in this research.

The Evolution of Irish Health Care

In order to fully understand Ireland's current health care system and the origins of its particular nuances, it is necessary to consider its evolutionary path. In the 18th Century medical relief for the poor in Ireland largely took the form of the provision of infirmaries. The government gradually undertook greater accountability in this regard when The Poor Law (Ireland) Act was passed in 1838. This law formalised the three-pronged approach of the Workhouses, the Infirmaries and the Poor Law Unions which effectively co-positioned the sick and the poor together; an early example of the institutionalisation of poverty (Barrington 1987). In 1851 the dispensary service was created which provided a salaried medical officer to each district, who also maintained their private practice in their remaining time. Barrington (1987) indicates that, even at this early stage, distinctions in the treatment of public and private patients were already emerging;

> 'Private patients were normally seen at the doctor's house. It was taken for granted that private and public patients should be seen in separate premises since "respectable" people feared catching infections from the poor' (Barrington 1987, p.11).

The role of voluntary and medical charities in the foundations of Ireland's hospital system cannot be understated. While what were later to become public hospitals had evolved from the Poor Law Infirmaries, many of Ireland's voluntary hospitals originated in the early 18th century, largely in urban areas and many through the involvement of religious orders (Curry 1980).

A number of attempts to reform the system of care and relief were seen in the early 1900s with the Vice Regal Commission and the Royal Commission whose reports made varying recommendations that aimed to eliminate the objectionable mixed workhouse system (Barrington 1987). However, the Poor Law Unions and the dispensary system would remain, even through the attempts to mirror Lloyd George's British scheme of health insurance. The National Health Insurance Bill (1911) was met with much criticism for its irrelevance to the Irish context and was opposed in its original form by both the medical profession and the Catholic

hierarchy. The Irish medical profession was, to an extent, split as some had concerns about potential loss of private practice while others argued for higher levels of rates to support the scheme (Cousins 2003). The intervention by the Irish Catholic hierarchy took the form of a statement issued in June 1911 opposing the Bill on social and economic grounds, thus illustrating that the bishops:

> 'viewed the issues raised by the Bill through predominantly rural and capitalist eyes and from the standpoint of the farmer and the small trader' (Barrington 1987 p.50).

Revised clauses were added to the Bill while much negotiating and trading ensued, but ultimately, medical benefit would not apply in Ireland despite a late change of mind from the medical profession who 'sought the re-inclusion of medical benefit for Ireland and dropped its demand for an increase in rates of payment (Cousins 2003). While unemployment benefit was approved through this Bill, the failure to implement medical benefits represents the beginning of a long trend that sees Irish health care failing to follow trends seen in other countries (Adshead & Millar 2003):

> '…although the debate surrounding free health care for all did not fade away entirely, it was clear from this point on that Irish healthcare would never be universally provided' (p. 11).

Barrington also emphasises the future and on going significance of this failure of the Health Insurance Bill in Ireland stating that:

> 'the bargains Lloyd George failed to strike in Ireland had profound implications for the development of Irish health services, and general practice in particular' (Barrington 1987 p.65).

The first Dáil in Jan 1919 established a Ministry of Health and in 1920 the Commission on Local government set about replacing the existing Poor law schemes with 'county schemes' and 'county homes', replacing the dilapidated workhouses, while leaving the dispensary system in place. More central state control was established after independence with the establishment of the Department of

Local Government and Public Health (Curry 1980) and Boards of Health in 1924. Further changes that followed included reform of the process of appointment of medical officers and changes to the dispensary service but, ultimately, much of the social policy developments of this era stayed close to the concept of retrenchment, a concept which Cousins (2003) suggests was regarded as inherent to the very notion of nationhood. The National Health Insurance Act of 1929 involved the adoption of select principles and recommendations, primarily those that were 'concerned with the promotion of efficiency and economy' (Powell 1992, p.171). Barrington (1987) also emphasises the economically focused and thereby limited effects of this Act that:

> '…implemented those parts of the [interdepartmental] committee's report which promised greater economy and efficiency and ignored those which advocated increased expenditure' (p.108).

Barrington goes on to point out that, again, 'the existence of the dispensary system was used to prevent the emergence of a less stigmatising system of medical treatment for those on low incomes' (p.108), an observation that can be seen to retain significance today.

The subsequent decade primarily saw the development of a general hospital service largely funded by the Hospitals Sweepstakes. Despite the influence of the world depression of the 1930's, government sought to invoke redistributionist measures and responded to calls to provide for the increasing numbers of unemployed with more than the highly stigmatised home assistance.

In the 1940s, increasingly convinced of the need for reform, and probably influenced by the publication of the Beveridge Report (Beveridge 1942) in Britain, a dedicated Department of Health was established. Efforts to combat tuberculosis also received attention with the publication of a White Paper on the matter in 1946 (Barrington, 1987). Other significant developments at this time included the Public Health Bill (1945), which included emerging plans for ill-fated mother and child provisions, and the success of the medical profession in winning the scalp of the parliamentary

secretary for Local Government and Public Health, Dr F. C. Ward; an exercise they were to repeat with the cooperation of the Catholic hierarchy a few years later.

By 1947 health functions were reconfigured so that Local Government, Health and Social Welfare were divided out into individual government departments. 1947 was, therefore, a very significant year in the evolution of Ireland's health system as it marked the beginning of a more centralised health system that sought to take 'the financial burden away from local authorities [..] passing it instead on to a central fund' (Ferriter 2004, p.502). The 1947 Health Act, however, drew significant criticism from both the medical profession as a whole and from the Catholic hierarchy (Peillon 2001). A proactive battle was fought, particularly by the medical profession, who feared the introduction of a state provided health service similar to that which was being introduced in Britain. Their efforts included publication in their own medical journals, writing critical essays in Catholic journals, challenges to the constitutionality of the Act, High Court summons' and an attempt to sue the Minister for Health (Barrington, 1987). The Catholic Church's activities engaged more direct means by writing formal letters of protest directly to the government claiming that the Act infringed the rights of the individual, the family, the Church in education and the rights of voluntary institutions. A delay in implementing the 1947 Health Act was forced when Fianna Fáil lost power and the inter-party government was formed. The young Dr Noel Browne was then appointed Minister for Health and, as is discussed in more detail in Chapter 6, he had a strong 'distaste for private practice' (Wren 2003, p.34) and said later in his biography, for example: 'I have always found the cash nexus between the patient and doctor indefensible' (Browne 1986, p.82). These deeply held convictions, coloured by personal experience and tragedy in his own life, set him on a course that was to result in bitter clashes with his own medical profession and the Catholic hierarchy, and ultimately in own political demise.

However, his plans to improve the treatment of TB resulted in real improvement. For example, in the 5 years after his appointment an additional 2,000 beds became available, the death rate dropped and a comprehensive BCG vaccination programme was introduced (Wren 2003). These achievements are significant when set against the backdrop of his efforts to pursue a substantial hospital building programme, and the fact that his attentions were likely taken up with the emerging battle with the

medical profession, the Catholic hierarchy and indeed emerging disagreements with members of his own cabinet, including the Taoiseach. The details of this crisis are discussed in depth in Chapter 6 of this thesis and they serve as a useful case study that is richly illustrative of the competing forces at play in Ireland's health and welfare systems. As Barrington (1987) states

> 'The evidence that real power in the country lay not with elected representatives but with the Catholic Hierarchy generated a crisis of confidence in the democratic institutions of the state and the ideals of republicanism.' (p. 218-219)

After Browne's resignation and the collapse of the inter party government, Fianna Fáil set about revising aspects of the controversial Mother and Child scheme but ultimately sought to implement the 1947 Act. The 1953 Health Bill extended entitlements to hospital services but offered a much 'watered-down' mother and child proposals (Wren, 2003 p. 39). Barrington sums up the net effect of the negotiations on health provisions saying that:

> 'The notion of access to all services on the basis of medical need alone gave way to complex eligibility criteria, largely based on income, varying from service to service' (Barrington 1987).

Such founding principles can be seen to continue to exert influence today. Considine and Dukelow reflect on the wasted potential of this period in the evolution of Irish Health policy, commenting:

> 'An opportunity to develop a comprehensive health service, free at the point of use, was lost, the legacy of which has endured to the present time' (Considine & Dukelow 2009).

By the late 1950s the costs associated with maintaining an expanding health service was becoming evident. A voluntary insurance scheme for the upper income groups was first mooted by a government appointed committee and legislation, the Voluntary Health Insurance Act, 1957 established a company called the Voluntary Health Insurance Board (VHI), complete with a government subsidy. The scheme

was extremely popular and within a year 57,000 people had chosen to insure themselves (Cousins 2003; Hensey 1979). However, interest in providing a free health service for all was still being proposed by both the Labour Party and Fine Gael, and the health service was an important issue in the general election of 1965 (Barrington, 1987). When Fianna Fáil were returned to office another new Minister for Health, Donogh O'Malley, took the reins. Outlining his plans for reform, he published the 1966 White Paper, followed later by The Health Bill, which he introduced to the house in 1969. A number of notable aspects of these strategy documents are worthy of note here and drew criticism from some circles at the time. Firstly, the papers opened with a robust disclaimer that:

> '…the government did not accept the proposition that the state had a duty to provide unconditionally for all medical services free of cost for everyone' (Barrington, 1987 p.261).

Secondly, the White Paper and the subsequent Bill introduced a new version of a classification of the citizen in terms of their "full" or "limited" eligibility for health services. Considine & Dukelow indicate the enduring nature of this feature that had evolved from a 1950s policy decision, saying that while these eligibility criteria have been modified 'this arrangement set in the 1950s, remains the cornerstone of access and entitlement in the Irish healthcare system' (Cousins 2003; Considine & Dukelow 2009).

A further development of note was the establishment of eight regional health boards, or functional areas. The rationale for this regionalisation of health functions was the 'inadequacy of the existing hospital services and the belief that they could only be properly developed on a regional basis' (Adshead & Millar 2003; Curry 1980).

Some improvements were achieved through this Bill including an improved eligibility free prescription drugs and the replacement of the dispensary system with a General Medical Scheme (GMS), allowing patients more scope to choose their doctor. It could be argued, however, that this induced a stronger role for the principle of fee-for-service payments. O'Malley had originally intended in his White Paper that a capitation system be put in place whereby doctors would receive an annual payment

for each of their GMS patients, but this was not accepted by the medical profession. The medical profession won further significant ground in later amendments to the Health Act, 1970 as greater opportunity was given to consultants in public health board hospitals to maintain their private practice. Wren makes the implications of this development very clear when she says:

> 'The 1970 Act therefore permitted the medical profession greater opportunities to earn private fees and discriminate in favour of fee-paying patients in local hospitals and opened up for general practitioners a whole new market for fees from state-funded GMS patients' (Curry 1980; Wren 2003).

Many of the developments and policy decisions over these decades can be seen to still have significant impact on the nature and features of contemporary health services in Ireland. The 1970s saw an attempt by Brendan Corish, a Labour Party Minister, to introduce free hospital care for all, quashed by threats from the hospital consultants who feared the loss of private practice income. This time the Catholic bishops did not get involved. A Fianna Fáil government came to power in 1977 and, with Charles Haughey as Minister for Health, succeeded in implementing an entitlement to free hospitalisation for all (a strategy he had opposed while in opposition). The richest 17% of the population would still have to pay for their own consultants' fees through 1% of their income. Burke notes that:

> 'This time, the consultants did not oppose it because private practice was a well-established and growing phenomenon, and consultants already had one fifth of the population paying private fees directly to them for the care they received' (Burke 2010, p.171).

As a result of new contracts, Irish hospital consultants achieved the hugely privileged position of receiving a salary from the state in a pensionable position whilst also earning significant income from private practice. As Wren (2003) comments:

> 'This consultants' contract turned heavily state subsidised, private medicine into a growth industry, encouraged the development of private hospitals staffed by consultants on state salaries and

> consolidated the two-tier system of preferential access for private patients in public hospitals' (p. 57)

The 1970s were economically depressed times when the realities of poverty levels in Irish households were becoming realised through major research evidence (Powell 1992). The subsequent decade of health policy in the 1980s could be summarised in terms of efforts to reduce spending in the form of cutbacks and efforts to reform administrative structures. As the public health system became increasingly overburdened with fewer resources, private access to health care became more appealing, resulting in greater inequity (Ferriter 2004, p.502; Considine & Dukelow 2009). The 1980s also marked a significant juncture when Ireland's spending on health dropped below the OECD average where it remained until a brief period in 2009 where at 10.0 it exceeded the OECD average of 9.6 (Considine & Dukelow 2009; OECD 2013). Furthermore, the 1980s was a time of relative political instability with 'severe economic constraints and three changes of government' (Burke 2010, p.34) in the first two years alone. Yet another Minister for Health came to office with promises to reform in 1983, when Barry Desmond, again without the support of his cabinet, spoke of a European style, freely accessible health service (Wren, 2003). Economic restraints did not allow these ambitions come to fruition. Instead Desmond was to become the minister who closed hospitals and 'savaged the health service' (Wren 2003, p.82). Yet, while the public hospital system saw 18 hospitals close during the mid 1980s the private sector grew in terms of the scope of private health care provisions and the number of citizens choosing private insurance (Wren 2003; Considine & Dukelow 2009). By 1990 one-third of the population had private insurance, an expense subsidised by the state through tax relief, while hospitals were being encouraged to 'convert' public beds to 'private' status so as to generate revenue (Wren 2003; Burke 2010). A fully-fledged two-tier state subsidised health system was now well established, with considerable incentive from state policies.

The Commission on Health Funding published its report in 1989 and in its recommendations for reforms of the health care system was 'critical of the two-tiered system of care' (Burke 2010, p.34). It recommended the establishment of:

> '…a unified, tax-financed and universal health system, leaving privately financed healthcare a marginal, voluntary and entirely financially freestanding role. Apart from "hotel" aspects of healthcare, it recommends that everyone should have the same right of access to healthcare, regardless of economic status' (McDowell 1989, p.1).

The report was ambitious in the manner that it argued for more equitable access to care and against any state support for private healthcare, however it stopped short of recommending free GP care (Burke, 2010). Unfortunately, the recommendations were not taken on board and the report was shelved.

> 'Had some key recommendations been implemented – common waiting lists, a fixed-term contract for consultants, the end of tax subsidies for VHI premiums, the effective abolition of the health boards – they could have turned the rising tide of demand for private medicine and rationalised the organisation of health services' (Wren, 2003, p. 84).

The 1990s were a time of continued attempts at reform while health and welfare issues remained significant political topics. A further division of the Eastern health board brought the total number of health boards in Ireland to 11 in 1999. A perceived need for cost containment and organisational reform continued to preoccupy those with responsibility for health policies. The Department of Health (and Children from 1997) produced numerous policy and strategy documents on various aspects of the health service, however continuity in such policy was challenged by the fact that 7 different ministers for health were in office for short periods in the 1990s.

This period of inconsistency ended when Brian Cowen held the position for 3 years (1997-2000), then Micheál Martin (2000-2004), before the longest serving Minister for Health to date, Mary Harney, took office (2004-2011). This decade saw a plethora of strategies, revised policies and commissioned reports. Under Micheál Martin a new health strategy, 'Quality and Fairness – A Health System for You', was launched in December 2001 and promised 3000 extra beds by 2011, significant cuts to waiting

lists and improved services for people with disabilities. While this strategy was ambitious, what it did not do was suggest any kind of alternative to the way in which citizens access their health services. As Burke (2010) points out:

> 'it did not propose a universal healthcare system, free at the point of delivery. It did not seek to change how health services were financed and reinforced the public-private mix which had become the acceptable form of Irish health service provision' (Burke 2010, p.43).

Another report, what became known as the *Prospectus Report* (2003), did propose a major reorganisation of the health services that would:

> '…make the health services more unified, efficient and streamlined and, some say, less vulnerable to local and parochial pressures' (Harvey 2007)

The health boards were to be abolished and replaced by a single organisation called the Health Service Executive (HSE) which would be responsible for 'executing policy, administering and managing' (Harvey, 2007, p.5). The Department of Health and Children would be responsible for deciding the policies to be implemented, while the Minister would be theoretically responsible for health services. The Prospectus Report (Prospectus & Wyatt 2003) also recommended the abolition or amalgamation of most of the 43 semi-state agencies involved in health and social care. Harvey (2007) comments that this new way of organising Ireland's health system was a significant change as it:

> 'marked a substantial shift from a decentralised , almost federal system to a national, unified, command system run on a much more technocratic basis' (p.5).

On the 1st of January 2005 the Health Service Executive (HSE) was established on foot of the Health Act 2004, with four regions. However, much of these rearrangements represented issues of governance and administrative or organisational reconfigurations that resulted in little actual improvement in health services at ground level. The two-tiered health system would persist, government

policy would continue to incentivise the private sector, and private patients would retain their privileged positions.

Persistent features

This descriptive storyline of the evolution of Ireland's health care system serves as an explanatory map of the route taken to the contemporary two-tiered structures that currently exist. The roads chosen by policy makers over the last century can be seen to have recurring features within their landscape. Those less privileged have been consistently subjected to degrading and stigmatising services. This feature of Poor Law persists to an extent today and is evidenced by the manner in which those with an ability to pay for private health care are privileged by more timely access to care. Another recurring feature that remains relates to the positioning of the medical profession, particularly consultants, into a powerful and influential role in health policy and service delivery. This dominant group have succeeded in shaping policy decisions, maintaining a strong private practice role and have shown their strength within the political sphere, to the extent that many health ministers might be seen to be fearful of challenging hospital consultants.

Another dominant group throughout the history of Ireland's health system is evidently the Catholic Church. While their days of total hegemony may be behind them, the church still exerts considerable influence in many spheres and their ethos continues to permeate many Irish hospitals and the practices within them. As was seen in the case of the tragic and avoidable death of Savita Halappanavar in 2012, there remain many areas of health practices that continue to be influenced by Catholic social teaching (Holland 2013).

A further feature of this landscape can be described as the absence of any genuine and realistic attempt to do away with the two-tiered system so as to provide a genuinely free health care system. Curry (1980) points to this patently clear truism when he says: 'In Ireland it has never been government policy to provide or endeavour to provide a fully free health service' (Curry 1980, p.145). The lack of commitment in this regard is evidenced, not only by the policy failures that have been eluded to here, but also through the level of spending on the health service. Spending on health reflects the extent to which a government regards health as a

priority, specifically, state-funded health. Nolan explains the pattern of such funding in Ireland saying:

> 'After years of expenditure growth barely in line with inflation during the 1980s and early 1990s, expenditure on the health service in Ireland has increased dramatically since 1997, increasing by nearly 80 per cent in real terms from 1997 to 2002. While Irish health expenditure as a proportion of GNP has increased from 7.3 per cent in 1991 to 8.2 per cent in 2001, health expenditure as a proportion of GNP has also risen across the EU and OECD, with the result that Ireland still ranks among the low spenders on health, in terms of health expenditure as a proportion of GNP' (Nolan 2005, p.1)

So, if we consider these features of the history of Ireland's health system; a system that has always privileged those who can pay privately, a powerful body of consultants that value private practice, a public system that is underfunded, a growing, incentivised and subsidised private health care sector, and a total lack of any convictions towards creating a genuinely free health system, then it is unsurprising that Ireland's inadequate and deeply inequitable two-tiered health system remains. Furthermore, it is also unsurprising that many citizens fail to see the inequity and unfairness that this system inflicts upon them. These features have endured for so long that they have become normalised and citizens as well as policy makers have become complacent, presuming that health care is a private individual worry, not something the state should provide. State provided care, after all, resonates back to destitution and degrading poverty.

Health care is seen instead as a marketable commodity in which individuals may invest and it reflects what Wren (2003) refers to as a 'consumerist philosophy of health care' (p.89). She reminds us that Ministers for health are candid about their convictions in this regard, citing Rory O'Hanlon as saying:

> "I believe in Ireland that if people want to pay for their own medical treatment out of their own disposable income, that is their right" (O'Hanlon, cited in Wren, 2003 p.89).

Similarly, another influential proponent of private medicine, Dr Jimmy Sheehan, founder of the Blackrock Clinic in Dublin, is quoted as stating:

> 'I think health is a bit like housing. People are entitled to different levels of housing' (Wren 2003).

This philosophy of entitlement and privilege is familiar in Ireland and has gone largely unquestioned for many years, as has been shown in this section. While recognising this phenomenon of entitlement and acceptance of a two-tiered system, what this thesis aims to do is to provide an explanation of precisely how this evolved. What processes, assumptions and discourses enabled our current conditions to have emerged and go largely unchallenged? Foucault encourages this critical approach saying:

> 'A critique is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kind of assumptions, what kinds of familiar unchallenged, unconsidered modes of thought the practices that we accept rest' (Foucault, 1981 cited in (Kritzman 1988, p.155)

It is just such a critique, which identifies unchallenged assumptions that this research seeks to accomplish.

Health Inequalities and the Social Determinants of Health

Inequalities in health, in the timeliness of accessible health care, and in health outcomes have long been recognised as a problem both in Ireland and internationally (Graham 2007; Wilkinson & Pickett 2009; Wilkinson 2010; Miers 2003; Marmot et al. 2008; Marmot 2013; Burke & Pentony 2011; Burke 2010; Kawachi et al. 1999). The social conditions in which we are born, live and work are largely responsible for determining much of our health, and indeed our longevity. Graham (2007) emphasises the interconnectedness of socio-economic inequalities and health inequalities and encourages the embedding of these two areas of research together.

> 'It is very hard to explain health inequalities without this broader societal perspective: very hard to understand how health inequalities persist over time and across generations without an understanding of how socio-economic inequalities are maintained over time and across generations' (Graham 2007 p.xv)

Within the Irish context the Think-tank for Action on Social Change (TASC) make a similar emphasis in the report 'Eliminating Health Inequalities; A Matter of Life and Death' stating that the motivation for publishing the report was:

> '…because of the interrelationship between economic and health inequalities. Higher levels of economic inequality result in poorer health for everyone, but especially for those on the lowest incomes' (Burke & Pentony 2011 p.v)

Such social conditions are discriminatory, and can be seen to align to class related lines as Marmot (2010) points out:

> 'People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the

> 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus' (Marmot 2010, p.4).

Yet a focus on the social gradient in health, for which Marmot appeals, is not prioritised in social policies despite much evidence.

Substantial evidence also exists that demonstrates differences in the socioeconomic inequalities in morbidity and mortality between countries (Mackenbach et al. 1997; Mackenbach 2006; Mackenbach et al. 2008). In the UK, as early as the 1970s, hard evidence of disparities of health outcome and mortality rates by occupational social class became indisputable with the findings of the much-cited Black Report (Department of Health and Social Security 1980), and these findings have continued to be verified by the subsequent Whitehall Studies (Marmot et al. 1991) demonstrating that 'people from lower occupational grades showed a steeper decline in physical health than those in higher grades' (Marmot 2010, p.159). While many of these reports have in the past been viewed with scepticism by governments (Ginsburg 1992), more recent indisputable evidence has demanded the attention of policy makers and governments.

The World Health Organisation (WHO) was sufficiently concerned with examining the social determinants of health as to establish the Commission on Social Determinants of Health (CSDH) in 2005 so as to 'marshal the evidence', on a global scale, on social determinants of health (SDH). This Commission was chaired by Sir Michael Marmot, a respected British epidemiologist and long-time advocate on the issue of inequalities in health. In 2007 the CSDH outlined a conceptual framework from which the commission worked. Drawing on theory from numerous sources their framework distinguishes between Structural determinants of health inequities, and Intermediary Determinants of Health, and emphasises the collective influences of various contexts such as Socioeconomic, Political, Social Class, Health Systems and Social Cohesion. However, this report also points out that a rarely researched subject within the area of SDH is that of the impact of policies adopted by governments. Further, this report also emphasises that the health system itself is a relevant factor influencing SDH, but that it is one that has not received adequate attention in the literature (CSDH 2007). It could be argued that all the social determinants of health can, in some ways, be traced back to the manner in which the

country is governed and the social policies and systems that therefore exist. The systems of education, housing, welfare, transport and health can be seen as inextricably connected and, arguably, equally influential on health outcomes.

The WHO's CSDH published its final report, 'Closing the Gap in a Generation' in 2008 and concluded that there was an ethical imperative to tackle the social determinants of health because 'social injustice is killing people on a grand scale' (CSDH 2008 p.vi). A genuine attempt to address the inequitable consequences of the social determinants of health, that is the 'health gradient', requires a rigorous examination and overhaul of a wide range of health and social policies. The connection between such social policies and health is also indisputable, and is emphasised by Marmot et al. (2008) who state, 'The health-care system is itself a social determinant of health, influenced by and influencing the effect of other social determinants' (p.1664). A similar point is made by Lundberg et al. (2008), in their study of the impact of welfare state generosity on public health, who conclude:

> 'The ways in which social policies are designed, as well as their generosity, are important for health because of the increase in resources that social policies entail. Hence, social policies are of major importance for how we can tackle the social determinants of health' (p.1633).

After the publication of the CSDH final report, the UK's Secretary of State for Health asked Sir Michael Marmot to set up and chair a strategic independent review group to propose strategies for reducing health inequalities in England. What became known as 'The Marmot Review' published its report 'Fair Society, Healthy Lives' in 2010 (Marmot 2010) and produced evidence of inequalities along with a number of required actions on policy objectives that needed to be implemented. Again Marmot and his colleagues sought to place the correction of health inequalities, and the social gradient in health, at the centre of government policies rather than being positioned as an inconvenient afterthought. Marmot emphasises this saying:

> 'This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus' (Marmot 2010, p.3).

The Irish Case

Incontrovertible evidence has demonstrated that Irish health care, and its two-tiered health care provisions, is deeply inequitable. Layte & Nolan (2004), for example, analysed the level of equity in the utilisation of health care in Ireland and demonstrated that these levels favoured the better off. Much of this type of evidence is presented quite matter-of-factly within the realm of health economics for example, as Wiley (2005) tells us:

> '…the proportion of the population entitled to free health care has dropped over the past two decades, whilst socio-economic differentials in health experience persist. Geographical differences in age-standardised mortality rates, in particular, are cause for concern and private patients continue to have better access to public hospitals than public patients' (p.184).

In one of its last publications before its dissolution, 'Tackling Health Inequalities An All-Ireland Approach to Social Determinants', the Combat Poverty Agency expressed concerns about equity of access to health care in Ireland's two-tier system:

> 'Although public patients tend to be older, sicker and poorer than private patients, there has been evidence of lengthier waits for treatments for those who rely on public hospital services' (Farrell et al. 2008, p.38).

This report goes on to reiterate many of the findings and recommendations of other European and WHO level reports and, like these other reports, emphasises the multifaceted nature of health inequalities and the consequent difficulty in generating simple evidence that would point to singular causes with simple resolutions. Instead, the report recommends that an approach that focuses on the social determinants of

health will succeed in ‘going beyond the immediate causes of disease’ and will therefore look to ‘upstream’ factors, or the fundamental ‘causes of causes’.

Socioeconomic factors are known to play a significant role in disease and chronic illness. For example, it is known that socioeconomic factors play a powerful role not only as determinants of health and wellbeing, but also that more unequal societies experience more enduring levels of material deprivation, thus a persistent cycle exists (Wilkinson & Pickett 2009; Marmot 2010). Poverty leads to ill health, exacerbating inequality, made all the more unjust by the inability of the poor sick to access affordable timely health care. However, much of the rhetoric that accompanies such evidence within the domain of public health tends to contribute to an individualised focus, rather than a socially determined, structural perspective. There is a danger that the individual poorer person is portrayed as having failed to succeed in securing health for themselves and their family due to their own personal failings. Their health is mapped against their educational attainment, against their occupational status, perhaps against their income level and an uncritical reader of such statistics may view such evidence as being a ‘lifestyle choice’. Within the Irish context, the ‘public patient’, the person without private health insurance, for example is represented as having ‘chosen’ not to opt in to this club of the privately insured.

Rather than considering individual health behaviours and decisions as somehow pivotal to health inequalities, there is a need instead for ‘an integrated and multifaceted response that takes full cognisance of societal and individual factors’ (O'Connor 2006, p.85). In 2007, The Public Health Alliance for the Island of Ireland produced a uniquely broad ranging report on Health Inequalities (PHAII 2007) that made concrete suggestions of policy decisions outside of health that they believed would reduce health inequalities. The PHAII located health inequalities as part of a broader issue of social exclusion and their work towards a fairer society, and in their report pointed to areas like taxation, employment legislation, housing, minimum wage and poverty reduction as structural factors, that is, the social determinants, that contributed to the social health gradient in the first place.

More recently, in 2013, the Irish Government launched 'Healthy Ireland' a document that forms a framework for improved health and wellbeing. Replete with aspirational objectives, this document lists 'Reduce health inequalities' as its second goal stating: 'Health and wellbeing are not evenly distributed across Irish society. This goal requires not only interventions to target particular health risks, but also a broad focus on addressing the wider social determinants of health – the circumstances in which people are born, grow, live, work and age – to create economic, social, cultural and physical environments that foster healthy living (Government of Ireland 2013, p.7).

Despite the obvious merit inherent in such goals, there is no substantial policy or strategy visible within this document that suggests that a wider direction will actually be taken that might genuinely result in addressing the social determinants of health and the health gradient.

It can be seen from the discussion here that a significant body of literature exists wherein health inequalities have been considered using a number of different approaches; in terms of actual health outcomes, looking at the relationships between individuals' socioeconomic and health status, while another source of attention has been measuring inequalities in access to health care. Clearly these related facets cannot be entirely separated from each other and have causative and influential relationships.

Health inequalities in general have been the subject of much international research in the fields of epidemiology and public health, to the extent that they can be seen to be regarded in many discourses as a 'given'. That is to say, common thinking is that we are clearly not all equal in a socioeconomic sense and that our health is linked to our socioeconomic factors and therefore our health is de facto unequal. However, such a simplified argument fails to address the critical questions with which this thesis is concerned, such as, why is it that these inequities are increasingly perceived as 'givens'? When did this become okay? Why is the commonly known and understood inequity in access to health care in Ireland okay here, but not acceptable under other types of health and welfare systems? What structural factors can be referred to as contributing to the current condition of Irelands health care? The very fact that these questions present themselves and remain unanswered is

evidence that Irish health and welfare has been under-examined and remains under-theorised.

The zealous rhetoric of neoliberalism, embraced by state policy makers in Ireland, has not only had a dissipating impact on societal cohesion, but its impact on health provision has been particularly maleficent. The current generations of young people and young adults have existed only in an Ireland where private health insurance is seen as a sign of status and indeed by some as an absolute necessity; this in itself symptomatic of a lack of faith in the publicly funded health system. The Irish citizen purchases health insurance for their family at a cost that up to recently had little competition and was dominated by one semi-state body. So dominant is the discourse of private health care that up to recently about half the population had private health insurance cover. This figure has fallen recently and is predicted to continue to decline with recessionary depth (The Health Insurance Authority 2010). Having welcomed Irish health care into the market, the invisible hand of market forces is now at work and, as will be discussed later in this thesis, some find themselves more vulnerable to these forces than others.

Driving Inequality

Issues of inequality are not recent. In his introduction to Rousseau's 'Discourse on the Origin and Foundations of Inequality among Men', first published in 1755, Patrick Coleman pointed out that:

> 'Throughout his [Rousseau's] account of civilization's advances he lays constant stress on the disparities in men's status and power and on pervasive distortions in the methods used to justify — indeed, aggravate — inequality' (Rousseau 1994 p. viii).

Such disparities in men's status persist today and, arguably, in a more stark manner than was visible at the time of the Enlightenment. The primary drivers of inequality have evolved from those seen in the 18th century, such as private wealth and capitalist social relations, to the addition of overt neoliberal government policies in current circumstances. Contemporary inequalities are well known, well researched,

observable, measurable and ought therefore be regarded as undeniable. The role of the welfare state in ameliorating for life's struggles in the face of these inequalities is a crucial element of a social contract between citizen and state and one that, in and of itself, is beneficial to society. Ginsburg (1979) makes this point when he says:

> 'The welfare state thus becomes a vital institution in the maintenance and reproduction of the organic solidarity which binds society together' (p.41).

Arts et al (2001), in their large scale study using cross-national survey data, also make clear the degree to which different welfare state regime types influence people's conceptions of solidarity, concluding that:

> 'there is a strong correspondence between the normative frames of solidarity – embodied by the various welfare state regimes – and their populations' preferred level of solidarity and their choices of justice principles' (p.297).

Similarly, in a study specifically looking at European citizens' attitudes to state involvement in their health care systems, Wendt et al. (2010) concluded that, 'individuals orientate themselves at specific institutional arrangements and that their attitudes are formed by these processes of orientation' (p.189). From these sources we can surmise that there is a clearly influential relationship between the health and welfare regime to which one is exposed and the attitudes towards such regimes that are consequently formed within that society. Logically then, it could be hypothesised that erosion of principles of solidarity and distributive justice within such health and welfare regimes is likely to result in deleterious effects on social attitudes to such principles. The principle of altruism is also a crucial feature in strong welfare states and this principle is strongly supported by theoretical literature such as that of the Gift Relationship (Titmuss & Oakley 1972). The assault on the welfare state, with which the next chapter is concerned, is therefore also an assault on organic solidarity, on altruism and on societal cohesion.

Structure of the thesis

This thesis is structured in such a way as to initially begin from a broad perspective on issues of health, welfare and social inequalities, drawing on core social theoretical literature. Earlier in this first chapter the broad range of empirical evidence on health inequalities, and on the social determinants of health, are discussed leaving little doubt as to the situation. The thesis then goes on to focus specifically on Ireland's health system which, through key case studies, is utilised as a microcosmic exemplar. Later chapters then gradually zoom out again from these specifics to the wider interpretations that are drawn from an analysis of the cases in a more abstracted context.

In Chapter 2, the location of health as a key component of the Irish welfare state is explored, but before that can be done, the differing ideological positions that contest the welfare state are examined in detail. Ireland's peculiar welfare state model is also considered in the context of traditionally accepted ideal types. This chapter also introduces the influential concept of neoliberalism, specifically in relation to its impact on arrangements of health and welfare provision in contemporary capitalist states.

Chapter 3 delves deeper into neoliberalism as a primary driver of a culture of individualism. In order to understand neoliberalism, and its impact on health and welfare, it is important to look to the origins of the ideology within the tradition of classical liberalism through the essential writings of Hobbes, Locke, Smith, Mill and others. This chapter then proceeds to trace the development of neoliberalism to contemporary interpretations and seeks to identify where distortions of understanding have occurred. Finally, Chapter 3 discusses neoliberalism in Ireland, specifically the mechanics of neoliberalism within a range of social and public policies, and, drawing on club theory, endeavours to explain its hegemony and the consequent subjectivisation of the Irish citizen.

Within Chapter 4, laid out for the reader, are the theoretical and conceptual tools that are used in the work of the thesis. The core instruments of the social contract, the gift relationship, solidarity and possessive individualism are introduced and examined systematically. A consideration of social contract theory takes the reader through a series of core theoretical texts including those of its critics. The manner in

which social solidarity has been conceptualised since Durkheim enables a particular perspective on social cohesion. Further, the core concepts of altruism and reciprocity are foregrounded in an exploration of the work of Mauss and Titmuss in relation to the gift exchange and the gift relationship, respectively. Macpherson's crucial political theory of possessive individualism also receives attention within this chapter in order to illuminate the nature of human relations in the social world within capitalist market societies. Finally, this chapter begins to demonstrate the ease with which these core theories appertain to the field of Irish health care, using them to better understand the current conditions of health and welfare in Ireland.

The methodological approach implemented in this thesis is the focus of Chapter 5. Here the genealogical approach informed by Foucault, and consequently Nietzsche, is examined and its appropriateness for this thesis is explicated. The prevalence of issues of power within Irish health care supports the selection of a genealogical approach that eschews the reproduction of dominant knowledge and challenges commonly made assumptions. This chapter then explores the Foucauldian conception of discourse as a subjectivating system of oppression.

Chapter 6 introduces the genealogies that make up the historical case study of Irish health care. After a short introduction to the intentions of the chapter, the story of each significant event is objectively told. Crucial contemporaneous discourses such as reports, letters, speeches in Dáil Eireann, newspaper coverage and others, illustrate the dominant narratives and, where possible demonstrates the minor or suppressed discourses. As each genealogy is told, some initial analysis substantiates the position of the cases within the context of the social theoretical literature explored in the earlier Chapter 4. Finally, Chapter 6 finishes with an amalgamation of the four cases in a brief discussion that brings the cases together and demonstrates the vectors between them.

A deeper discussion of the genealogies is provided in Chapter 7 where a systematic critical analysis demonstrates two core themes and their secondary sub-themes that emerge from this research. These themes serve as a framework for the remainder of the chapter where the cases are analysed through the critical lens of the core theoretical concepts introduced in Chapter 4.

The initial core theme that is discussed in this chapter relates to the normalising effect of dominant discourses that succeed in achieving a degree of social acquiescence. Closely related to this accomplishment of normalcy is the concept of solidarity and its antithesis; individualism. An opportunity is therefore taken in this chapter to discuss in detail the concepts of individualism and solidarity, which are then explored within the context of the genealogies.

In addition, the overarching theme of power and of hegemonic influences is manifested through an analysis of all of the four genealogies revealing the protection of those with vested interests, to the detriment of the subordinated and vulnerable. Further analysis within this chapter demonstrates that each of the genealogies is illustrative of fundamental concerns in relation to the role of the welfare state under neoliberalism.

Chapter 7 concludes by pointing towards some tentative conclusions that are discussed in greater detail in the subsequent chapter. Finally, Chapter 8 summarises what it is that this research has shown and, while moving back out from the specifics of the case study of Irish health care, examines what these findings actually mean within the context of contemporary life within a neoliberal capitalist state. This chapter returns to the core theoretical constructs to ask how these have functioned in the analysis of Ireland's current conditions and to explore the potential for the ideals of the social contract, of the gift relationship and of solidarity in an era of individualism and near total capitalism.

Why this thesis, this way?

Ireland presents as a particularly unique site for the examination of ideas around health, welfare, individualism, altruism and solidarity. Its history as a post-colonial republican state, with a health and welfare system in many ways grossly inferior to its nearest neighbour, alongside prolonged subjection to the hegemony of a powerful Roman Catholic Church, contribute to its usefulness for an examination of issues of power. In addition to this, the long history of charitable and voluntary sector involvement in health and welfare concerns in Ireland, as discussed earlier in this chapter, intensify this complicated mix. These factors all contribute to a further defining feature of interest to this thesis; that is, the absence of critical voices that might challenge or question dominant discourses. The methodological approach taken in this research, a historical approach informed by Foucault's genealogy, is therefore particularly appropriate given that it seeks to critique embedded assumptions and to challenge the dominance of discursive formations through which power is exercised. Such objectives could not be met through a quantitative method, which would fail to produce a new understanding.

It could be asked why no new empirical data was collected for the purpose of this thesis. The answer simply is that there was no need. Ireland's history is crammed with data, as is the present situation. Examples include the closing of hospitals, the absence of primary care services, the massive gulf in waiting times between public and private patients, the colocation of private and public hospitals, the lack of social housing in Ireland, the restrictions on access to medical cards for disabled children, the increasingly disciplinary measures within the social welfare system, and the primacy of private health insurance companies within Irish health care. All of these are consequences of social policies influenced by dominant discourses and derived by governments from the distortion of archaic ideologies. This history, congested by critical junctures, demands to be examined in a new manner, rather than having its measurements of inequalities and injustices measured for a further innumerable occasion. Alternative research approaches such as interviews with individual gatekeepers or service users would have failed to offer the understanding of the origins of specific discourses, which are sought in this research.

In order to understand the process of the formation of knowledge and understandings surrounding Ireland's health system a historical perspective,

informed by Foucault's genealogy was selected. Foucault explained this design stating:

> 'And this is what I would call genealogy, that is a form of history which can account for the constitution of knowledges, discourses, domains of objects etc.' (Foucault 1980, p.117)

For these reasons, a qualitative, historical study, informed by the fields of sociology and social policy research, is offered in this research. The justification for the specific methodological approach of a historical genealogy is explicated in more detail in Chapter 5. The selection of multiple cases satisfies the need to examine discourses surrounding different issues within the health care paradigm, and within different political and economic time periods. This research approach, therefore, derives from the work of Foucault, while the use of a 'cases', or genealogies, serves to enable the examination of historical events within their particular contexts.

Chapter 2: Typologies of Welfare: Locating the Irish Welfare State

Introduction

The contemporary welfare state has evolved over many decades from an original, normatively grounded aspiration to correct inequalities by providing safety and security for the vulnerable in societies. It is often referred to as assuming the form of a social safety net. However, more recently the ideological driver can be seen to have shifted from one of protective altruism for the common good, to a more market–driven strategy. Instead of providing what Bauman (2005) refers to as 'a collective guarantee of individual dignified survival' (p.45), the welfare state may be seen as adopting punitive features more familiar to a criminal justice system with similar issues surrounding stigma.

This chapter will first examine the various ideological positions that contest the entity that is the welfare state. It is important to note the wide variety of schools of thought towards the welfare state and to acknowledge that they range from 'open hostility, to apprehensive acceptance, to obvious enthusiasm' (George & Wilding 1985, p.125). Following this examination, the chapter will proceed to map the development of Ireland's welfare state, and will attempt to distinguish it within the typologies as identified by Esping-Andersen (1990) with the intention of examining whether another continuum exists, other than that of commodification and decommodification, that might more precisely map the tension between the private versus the social.

The discussion that follows will focus primarily on the Irish welfare state, but will draw on examples from other countries also. This exploration will acknowledge the influencing factors likely to have directed the development of Ireland's welfare state model. Further, this section of the chapter will argue that the contemporary welfare state is, in many respects, more disciplinarian than it is emancipatory, acknowledging that the perspective of those reliant on the welfare state is likely to be very different from the perspective of others. This distinction is important and it touches on the crucial issues of stigma, status and commodification, which will be

discussed in this chapter. Furthermore, notions of responsibilisation, and the subsequent disciplinary turn, arguably contribute to the process of individualisation.

A discussion will follow identifying the varying views in current literature on the extent to which current welfare state arrangements are influenced by neoliberalism, and will examine current challenges to the welfare state including common discourses of dependency, the neoliberal agenda, globalisation, workfare and related retrenchment. (A more thorough examination of the concept of neoliberalism and its origins will follow in chapter 3). The concluding passage will attempt to propose a future survival strategy for the welfare state that focuses on a return to collective values and the goal of emancipation.

Ideologies of the Welfare State

The diversity of ideological bases that surround opinions on the welfare state reflects the similarly diverse views on core issues such as political economy, capital, the role of the state in welfare and the position of the market in society. These different perspectives have been summarised very well in a number of core British texts such as George & Wilding (1985) and Williams (1989) although with slight variation. George and Wilding identify four groups of thinkers whom they have classified broadly as The Anti-collectivists, The Reluctant Collectivists, The Fabian Socialists (broken down further into three wings) and The Marxists. The classification of perspectives offered by Williams (1989) is similar to that of George & Wilding's, but through her Feminist critique of the welfare state she offers a further division of the Social reformists (similar to the Reluctant Collectivists) breaking them into three types; Non-socialist Welfare Collectivism, Fabian Socialism and Radical Social Administration' and, furthermore, she adds the Feminist Critique and an additional 'Anti-racist Critique' (p.17).

The key areas on which these groups differ or agree centres on their attitudes to the related values of Freedom and Equality, moving the secondary values of Individualism, Fraternity, Humanitarianism and Pragmatism, according to George & Wilding, into a subsidiary role to 'to support, to refute, to enlarge or to qualify' (p120), the core values. Freedom, and by association Liberty, is a primary value for the group referred to as the Anti-collectivists who argue for a reliance on an unregulated

market system to ensure an absence of coercion, particularly state coercion, which they see as an attack on their individual freedom. This school of thought regards inequalities as natural occurrences and repudiates egalitarian or social justice policies as they are incompatible with freedom (George & Wilding 1985). For these reasons the Anti-collectivists, such as Hayek, Friedman and Thatcher have argued for minimising the state role in providing welfare instead supporting the freedom of the market.

Freedom and liberty remain a core principle of the Non-socialist Welfare Reformists, or the Reluctant Collectivists as George & Wilding refer to them. The writing of Keynes and Beveridge for example, support the pragmatic but minimal involvement of the state intervention, alongside private or voluntary provision, to provide for welfare so as to alleviate deprivation and they reject pure egalitarian policies, preferring more conditional values around regulation. This school of thought is seen to have less faith than the former Anti-collectivists have in an unregulated free market system, believing instead that social policy 'compensates for and supports economic policy' (Williams 1989, p.21).

The Fabian Socialists engage in a total commitment to the parliamentary democratic process and participation, for which they believe Equality and Freedom as core values must be predominant, and they demonstrate unequivocal support for social welfare services (George & Wilding 1985). Citing the associated writers such as Tawney, Titmuss and Crosland, Williams (1989) clarifies the Fabian attitude to state welfare stating:

> 'The welfare state is central to the transformation of society through redistribution of wealth and the creation of a more equal, just and harmonious society to counter the inequalities of the private market' (p.16)

In addition to Equality and Freedom, the Fabians refer to Fellowship as an important value that, along with Equality, contributes to their strong belief in humanitarianism. The Radical Social Administration perspective that Williams identifies, calls for a

welfare state that is 'central to a socially planned society which consist of radical redistribution of wealth and resources and the pursuit of equality' (p.16).

The Marxist perspective, as seen through the writings of Marx, Engels, Offe, Gough and Ginsburg opens the lid on many of the paradoxes evident when examining ideologies of the welfare state. While one might have thought while reading through these perspectives that by moving from right to left that the depth of belief in the role of the welfare state would grow incrementally, but, counter intuitively, this is not the case. The Marxist perspective, or the Political Economy of Welfare as Williams (1989) refers to it, not unlike the other schools of thought, holds Freedom, Liberty and Equality at its core. However, the interpretation of these values, and what they mean for their views on the welfare state, are rather different. Their understanding of Freedom concentrates more on the removal of obstacles that inhibit opportunities towards human emancipation and self realisation (George & Wilding 1985) and in so doing the Marxist view condemns the free-market system out of hand. A distinction can be seen to emerge within these differing understandings between freedom from and freedom to. A Marxist perspective is concerned with enabling freedom from the ills inherent in an inequitable class orientated system, whereas the libertarian worldview focuses on securing freedom for individuals.

Furthermore, the Marxist perspective sees the welfare state as a source of support and strength for the capitalist system which, George & Wilding believe is one of the strengths of this approach because '…it locates the welfare state within the context of a particular economic and social system rather than seeing it in isolation' (p.138). Indeed, the Marxist view of the welfare state is a very critical one that has included seeing it as 'a repressive mechanism of social control', and as a 'means of controlling and/or adapting rebellious and non-conforming groups in society to the needs of capitalism' (Gough 1979, p.11). This view of the welfare state as an agency of oppression can be seen as in opposition to the view that holds it as an antidote to free-market capitalism's ills. Gough supports this idea of the welfare state as a contradictory phenomenon in this way as it '…exhibits positive and negative features within a contradictory unity' (p.11) and he refers to the 'recurring conflict between the "social wage" and "social control" aspects of welfare policies' (p.150). Using Marxist political economy as a theoretical approach, Gough argues that all social services

'combine elements of control and service provision' (1979, p.4) and that it can be used to impose sanctions as well as benefits.

So instead of viewing the welfare state as a mechanism for improving upon the capitalist system, Marxists see the welfare state as a legitimising source of support for it. Ginsburg (1979) also makes this point about legitimation stating that, 'The phrase "welfare state" conveys the benevolent and responsive appearance from which many liberal, capitalist governments derive substantial legitimacy' (p.3). He goes on to point out that many of the commonly cited flaws of modern welfare states, such as excessive bureaucracy and lack of democratic control are far from incidental issues in need of reform:

> 'On the contrary, they play a central role in fulfilling some of the essential functions of capitalist welfare, rationing benefits and services according to ideological criteria of deservingness, and containing individual and collective pressure for change' (Ginsburg 1979, p.5).

A further point of note is the Marxist critique of the welfare state that sees it as an instrument for reinforcing class divides. 'There is considerable evidence that, in fact, the welfare state institutionalises class, gender and racial divisions and inequalities' (Ginsburg 1992, p.2). For these combined reasons of control, legitimisation of capitalism and class division, the welfare state is seen by Marxists as 'an outcome of fundamental conflict between capitalism and working class' (Williams 1989, p.16).

Williams' identification of the Feminist Critiques perspectives points to the welfare state as a potential provider of material necessities that might improve women's lives, however she also suggests that it 'reinforces female dependency and the sexual division of labour' (p.17). Ginsburg supports this criticism stating:
'Patriarchal gender division is certainly a fundamental characteristic of individual welfare in industrial societies. Welfare states have played an important role in both reinforcing male supremacy, and, under pressure from women's movements, in transforming it to some extent' (Ginsburg 1992, p.6).

Williams expands her framework of feminist perspectives so as to identify six categories of feminist theories or approaches each of which offer slightly varying explanations of why women are oppressed (Williams 1989) but she emphasises the significance of Radical Feminism, Socialist Feminism and Black feminism because these are, in her opinion, 'the most significant approaches in feminism in Britain today for the theory and practice of welfare policy' (p43). Issues of race and anti-imperialism are paramount in what Williams refers to as the 'Anti-racist critique' of the welfare state. This perspective places the welfare state as part of institutionalised racism in a society where 'state policy reflects shifting relations between imperialism, capitalism and patriarchy' (Williams 1989, p.17). As a mechanism of institutionalised racism the welfare state may be seen to deny access to provisions, to offer second-class provision, to reproduce racial divisions and to maintain immigration controls.

The plurality of explanations of the different perspectives on welfare provide an illumination of the range of human experiences that are by definition involved in the welfare state systems and the manner in which an examination of these experiences, through a variety of theoretical lenses, reveal differing ideologies upon which welfare systems are built. While the perspectives on the welfare state outlined above feature significant differences, Gough, however, emphasises that there are in fact similarities among the different perspectives in that:

> 'Common to all is the view that the purpose of the welfare state is the enhancement of human welfare, the imposition of more enlightened values over those embodied in the capitalist market system' (Gough 1979, pp.2-3).

A further commonality is that all perspectives are working from taken for granted assumptions about the economy and the state in advanced capitalist countries. Indeed, this point can be taken further so as to acknowledge that 'Advanced capitalist countries both require but cannot afford a growing level of state intervention in the welfare fields' (Gough 1979, p.14).

Clearly the welfare state represents a highly contested field around which there is little consensus but many differing perspectives. The criticism of the welfare state

from the left (its controlling nature that reproduces class divides, engagement with false consciousness and its inherently contradictory nature) and the criticism from the right (its creation of dependency and the state interference in the labour market), paradoxically result in both sides desiring the same outcome, although from widely different ideological perspectives. Having explored the ideological critiques of the welfare state it is now appropriate to examine the field of welfare state typologies and to seek to explore the problematic issue of distinguishing the Irish type.

Defining the Welfare State

In order to examine the character of the Ireland's welfare state, this section will explore the commonly accepted models of welfare regimes, as identified by Esping-Andersen (1990) in his 'Three Worlds of Welfare Capitalism'. Esping-Andersen's taxonomy of welfare state types suggests that variations in welfare regimes are clustered in various countries. He proposes three types: The Liberal welfare state; The Social Democratic and the Conservative-Corporatist welfare state. He describes the liberal regime as a minimalist provision that seeks to encourage citizens to be self-reliant within the market environment. This system invokes strict entitlement controls resulting in a sense of stigma for those obtaining the modest benefit. In this liberal welfare regime the individual is expected to insure themselves against various risks and the distinction between 'deserving' and 'undeserving' poor is strong.

The conservative-corporatist welfare state type tends to have a strong focus on status, with rights associated with class, family and status. 'The state's emphasis on upholding status differences means that its redistributive impact is negligible' (Esping-Andersen, 1990, p.27). This model is strongly influenced by the significant role played by the church and it places the male breadwinner at the centre of the family unit. State assistance in this model is as 'provision of last resort since individuals are expected to first seek help […] from family, charity, church…' (Fitzpatrick 2005, p.106).

The third welfare state type identified by Esping-Andersen is the social democratic regime which favours the principle of generous universality. This model seeks to 'promote equality of the highest standards, not an equality of minimal needs' (Esping-Andersen 1990, p.27). The access of all citizens to provisions in this model

avoids stratification by entitlement (Bannink & Hoogenboom 2007). The social democratic regime establishes the prominence of social citizenship and solidarity, thus reducing the significance of the market and 'a strongly interventionist state [is] used to promote equality through a redistributive social security system' (Bambra 2007, p.1098). In addition to the commodification spectrum, Esping-Andersen also focused his model on issues of state/market relations as well as stratification (Lewis 1997).

Bannink & Hoogenboom (2007), among others, offer some critique of the simple delineation of Esping-Andersen's model. They suggest that the distinction between the three types of welfare regimes relies too heavily on the 'decommodification' level; that is 'when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market' (Esping-Andersen, 1990, p.21-2). Further, they question Esping-Andersen's system of stratification relating to status positions. Bannink & Hoogenboom (2007) argue instead 'that "hybrid" instead of "congruent" welfare states exist empirically' (p.24).

Further criticism of Esping-Andersen's typology is offered by Bambra (2007) who offers an overview of the multiple sources of critique of The Three Worlds typology within the comparative social policy literature. This criticism ranges from disagreement with his classifications, identification of the absence of gender issues in his classification, disputing methodological issues and miscalculation of statistical tests. Some efforts to reproduce Esping-Andersen's research has reported differing results and a suggestion that decommodification indices are not strong elements of regime classification (Scruggs & Allan 2006).

Suggestions that the analysis of welfare regime types by Esping-Andersen is 'gender-blind' have come from Orloff (1993), Sainsbury (1994) and Lewis (1997), among others, and generally highlight a failure to acknowledge the role of women and the family in his analysis of the state-market nexus (Sainsbury 1994). Orloff (1993), for example states:

> '…the concept of decommodification does not fully apply to women workers and is misleading concerning the situation of male workers

> because it ignores who does caring and domestic labor — and who are the beneficiaries of these domestic arrangements (p.322).

Lewis (1997) emphasises the importance of 'developing gender-centred measures, particularly around caregiving' (p.170) and argues that 'women's relationship to paid work, unpaid work and to welfare makes the search for gender-centred measures complicated' (p.160).

The accumulative effect of these numerous criticisms of Esping-Andersen's typology do not serve to negate the framework in its entirety but merely serve to provide a need for deeper analysis of welfare regime types and an acknowledgment that the composition of welfare state regimes is not static (Bambra, 2007). The concepts of 'decommodification' and of 'stratification' remain crucial to the objective of examining the extent of disciplinary or emancipatory features in the contemporary welfare system. A welfare system that focuses on minimal needs, exerts a minimal decommodification effect and stigmatises those 'reliant' on it through stringent means-testing, surely fails to emancipate from anything other than utter destitution. It can be argued, therefore, that the emancipatory nature of a welfare state is correlated to its decommodification effects and is inversely related to its tendency to stratify.

Alternative Typologies

Since Esping-Andersen's *Three Worlds,* and the threefold typology therein, there have been numerous attempts to rework his model into alternative constructions. The extent of research in this domain and the subsequent theoretical evolution has not necessarily clarified matters.

> 'The result is that the welfare state modelling literature is in a state of confusion and inertia as it is unclear which of these competing systems of classification is currently the most accurate or useful and which are less so (Bambra 2007a, p.2).

Much criticism has focused on Esping-Andersen's failure to acknowledge other important areas of welfare services including health care provisions. Moran (2000) offers an alternative typology when he emphasises the importance of recognising the centrality of health care for a true understanding of the welfare state. Referring to

three main characteristics of health care governance (Consumption, Provision and Technology), he identifies four distinct families of health care states, which he designates as: Entrenched command and control states; Supply states; Corporatist states; and Insecure command and control states.

Another alternative to the Three Worlds typology is offered by Reibling (2010), for example, who explains that the attentions of more contemporary welfare state typologies have focused on the public-private mix of health systems. However, she feels these 'overlook the second principle that was at the core of Esping-Andersen's welfare regimes: the principle of de-commodification' (Reibling 2010, p.6). De-commodification is central to welfare state regime because it defines the degree to which '…citizens' welfare has been uncoupled from their market position' (Crow 2013, p.89). Reibling offers an alternative typology, referring to it as:

> 'an analogy to de-commodification for healthcare by proposing access as a central dimension for the comparative analysis of health systems. […] putting access at the centre of a health typology strengthens a patients' perspective and thereby the impact of health services on individual health' (Reibling 2010, p.6).

Her typology, focusing on the issue of access, provides four distinct robust types of health care access which she refer to as *Financial incentive states; Strong gatekeeping and low supply states; Weakly regulated and high supply states;* and *Mixed regulation type states.* It is difficult to distinguish how to categorise access to health care in Ireland according to this typology, primarily because the two tiered health system in Ireland enables vastly different modes of accessing health care. This distinction between private and public patients is emphasises in a later publication by Reibling and Wendt (2012) distinguishing systems of gatekeeping access to health care in 17 OECD countries. Robust gatekeeping aims to improve 'efficiency, quality and equality and to contain costs' but, the authors warn, may have 'potential drawbacks for patient autonomy' (p.490). The authors rate Ireland's system as similar to the US, stating:

> 'Several countries have variant systems of gatekeeping systems and provider choice regulations within their own borders such that

> parallel systems of patient choice exist within a single country. We report two such systems for both Ireland and the US, since both coexisting schemes have very different regulations and each covers a significant share of the population (more than 30%)' (Reibling & Wendt 2012, p.497).

They go on to explain the clear distinction between public and private patients within the two-tiered arrangement:

> 'Coverage in Ireland can be differentiated between Medical Card Holders (Ireland I) and the rest of the population (Ireland II). Other countries, such as Germany, also rely on two-tier systems, but the percentage of coverage in the second tier is smaller than in Ireland and the US' (p.498).

It is important and indicative to note that in their distinctions of gatekeeping systems, Ireland is the only country that they need to divide into two and furthermore the two population groups enjoy vastly different levels of access to care through entirely different modalities of gatekeeping.

Bambra (2011) has been an influential author in challenging social policy researchers, alleging an overreliance on Esping-Andersen's *Three Worlds* typology, which she regards as inadequate. She summarises the various challenges to the Three Worlds model as being about:

> '…which principles should be used to classify welfare states […]; in which regimes particular countries belong […]; the number of different regime types […]; the methodology of regime construction […]; and the nature of gender stratification within different types of welfare state […]' (Bambra 2007a, p.2).

Instead, Bambra provides an alternative range of four broad types of welfare state regimes that enable more accurate analysis of cross nation comparative data (Bambra 2007b). She labels these types as 'Liberal/Residual', 'Conservative / Corporate / Bismarkian', 'Social Democratic/Scandinavian', and 'Southern/Latin'

(Bambra 2011, p.741). Once more it is challenging to place Ireland entirely into one of these categories, largely because, as identified by Reibling and Wendt (2012), Ireland effectively has two health care systems for two distinct population groups; those with private health insurance and those without. Government policy clearly incentivises private individualistic approaches to health care and indeed subsidises the private sector to a considerable extent while underfunding the public system. In these contexts Ireland's overall health and social policies are of the liberal, least generous regime type.

Comparative research of welfare regimes is evidently of great value, but also, it would appear, is at risk of confusion due to a lack of consensus on the use of particular typologies. Crow (2013) warns of the dangers of over-typologizing giving the view that:

> '…the purpose of comparison is undermined if the main conclusion reached is that every case is unique. The identification of types of welfare state or society is pursued in order to highlight broad patterns of similarity or difference, with a view to determining the crucial influences on their operation and trajectories' (Crow 2013, p.94).

Esping-Andersen's typology was only ever intended to indicate some categories of ideal types of regimes. It would appear that in an effort to apply his typology too rigidly 'some have confused the concept of "ideal types" with "real types" (Ferragina & Seeleib-Kaiser 2011, p.584).

Ireland's Welfare State

It remains difficult to locate Ireland's welfare state particularly when relying upon Esping-Andersen's (1990) model of typologies and yet, despite its criticisms, many discussions of welfare state types tend to rely heavily on the location of the regime along a commodification/decommodification spectrum. Arguably, there is no homogenous welfare state type that is useful in defining the Irish context. Ireland's welfare state cannot be seen to fit precisely into any of the three types identified. Clearly it is not a social democratic model, as the Irish system favours a wide use of means tests and has been seen to shy away from establishing truly universal provisions (other than child benefit). Instead, it could be argued that Ireland's welfare state resembles a hybrid of residual features of the conservative-corporatist and liberal models. Bannink & Hoogenboom (2007) in their examination of the Dutch hybrid model, suggest that welfare states tend to become hybrids in an attempt to become more stable. Ireland's welfare state can be seen to have evolved from a more distinctive set of circumstances that result in the difficulty of typologising. While the British welfare state emerged from a very unique post war state where there existed a relatively solid consensus around welfare, Ireland's more incoherent social policy around welfare issues on the other hand has emerged as a result of a vacuum where other actors (church, voluntary organisations, philanthropists etc.) have stepped out.

The role of the church, identified by Esping-Andersen as influential in his conservative-corporatist model, is also deserving of comment within the Irish context. Cousins (2005) while acknowledging the significant role of the Catholic church in the development of the Irish welfare state, warns of adopting a type of religious reductionism. He acknowledges the 'extent of Catholic involvement and control in other areas of social policy, such as education and health…' (p.127), but indicates also that the church's involvement in the welfare policy has been largely in preventing the adoption of policy to which it objected, rather than pursuing particular measures. O'Cinneide, back in 1993 however, was of the belief that, 'The fact that Ireland is peripheral, recently industrialising and Catholic is assumed to have determined the kind of welfare state that exists in Ireland' (O'Cinneide 1993, p.99). Powell and Guerin (1997) on the other hand are more definitive on the role the Catholic Church has played in the modelling of the Irish welfare state in the 1950s.

They point to the commentaries from the church at the time of the attempted introduction of free health care for mothers and children. Such state involvement was undesirable in terms of Catholic social philosophy 'which viewed negative state interference (i.e. policing) as permissible but regarded positive state action (i.e. welfare) as unacceptable' (Powell & Guerin 1997, p.38).

Cousins (2005) identifies a number of influences on the development of the Irish welfare state including Ireland's colonial and post-colonial status, the importance of agriculture, the role of Catholicism, the place of the family, the impact of being a dependent peripheral country and the role of the state. More recent literature has examined the role of globalisation on welfare state developments. Genschel (2004), for example, identifies three distinct schools of political scientific thought on the relationship between the welfare state and globalisation (Globalists, Sceptics and Revisionists). Of more interest, perhaps, is his explication of two theses of the likely future movements of the welfare state in the context of increasing levels of globalisation. Genschel (2004) defines what he refers to as the compensation thesis (that the welfare state will grow as a consequence of globalisation), and the globalist convergence thesis (that globalisation will result in a shrinking towards a minimalist welfare state). The domestic factors identified by Genschel (2004) as influencing a nation's reaction to globalisation (political factors, regime type, religious ethos) are comparable to those influencing the welfare state (Cousins, 2005). Clearly both the status of the welfare state and the level of globalisation impacting on a state are co-influencing factors. Ferrera (2008) states that globalisation has affected the welfare state by:

> 'posing new constraints, by restricting the margins of manoeuvre that national governments enjoyed during the golden age in designing, managing and funding their social protection systems' (p.86).

With these numerous influences in mind, where does Ireland's welfare state fit into a model of recognised types? O'Connor (2010) is in little doubt as to the nature of Ireland's welfare state when he says:

> 'The evidence clearly points to Ireland having developed into a liberal welfare state: Ireland has a total tax revenue of 30 per cent of GDP, second lowest only to the USA out of 21 OECD countries; its level of public social expenditure is the lowest of the 21 countries, marginally lower than that of the USA at 15.9 per cent; Ireland's public spend on education is second lowest only to Slovakia at 4.14 per cent of GDP; its overall level of government spending at 33.7 per cent of GDP is also the lowest, less than the USA which stands at 34.3 per cent of GDP' (p.1).

The implications of such a level of social expenditure will now be examined within the context of Ireland's tendency to a strategy of subsidisation.

Ireland's welfare state & state subsidised individualism.

It must first be acknowledged that any model of welfare regime types is, by definition, a description of an 'ideal type' (Bambra 2007) and therefore Ireland, a country that many would argue has not experienced a true welfare state, is exceptional and difficult to locate within a model. Instead, Ireland's welfare state is more accurately described as possessing some features of a Liberal welfare state model, other features of a Social Democratic model, and then other features that might more appropriately belong to a Conservative/Corporatist model. However, the Irish type fails to fit any of these 'ideal' types in a substantial way. It is important to accept that there is no tidy fit and that typologies such as that offered by Esping-Andersen provide merely a generic framework in which Ireland's welfare state straddles multiple features.

In response to the argument that Ireland does not in fact have a welfare state, some might point to economic indicators such as the percentage of GDP spent on welfare type interventions (40% in 2011). However, a deeper analysis of this spending reveals Ireland's deficient welfare state located on a different spectrum. Using a spectrum of universalist on one end and individualist on the other we can see that State spending on welfare in fact subsidises the individual in a manner that serves to encourage individualised strategies towards meeting citizens' needs. We could call

this 'state subsidised possessive individualism'. On the face of it Ireland may appear to have a highly interventionist welfare state with a state that is fulfilling its role, however, the emphasis on engaging private sector actors (such as private landlords, privatised childcare, private health care) and subsidising the citizens to engage with them in their market, creates a different reality. The reality is in fact one where the citizen with rights recedes and instead is transformed into a consumer of services, cultivated and subsidised through policies of the state, lured by the promise of 'choice'. Ireland is unlikely to be unique in this regard and other examples could certainly be found, however it is the particular circumstances of the Irish conditions that are of interest to this thesis.

The political and economic system surrounding Ireland's welfare state has been influenced and governed by the principle of subsidiarity. This historical economic principle has its roots in the somewhat incompatible realms of classical liberal economic thinking and, in the Irish context, Catholic social teaching. Focusing on the issue of the distribution of responsibilities between state and society (Fouarge 2004), the subsidiarity principle 'states that economic activities that can be efficiently carried out by the market should indeed be undertaken by it' (Fouarge 2004, p.3). The principle appeals to liberal thinking as it 'sharply contradict[s] despotism and fascism' (Fouarge 2004, p.28).

Emerging in medieval Christian philosophy, the principle of subsidiarity became associated with Catholic social teaching when, in 1931, Pope Pius XI endorsed this economic principle and in so doing imbued the principle with a moral and religious quality, writing:

> 'It is an injustice and at the same time a grave evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organizations can do. For every social activity ought of its very nature to furnish help to the members of the body social, and never destroy and absorb them. The supreme authority of the State ought, therefore, to let subordinate groups handle matters and concerns of lesser importance, which would

> otherwise dissipate its efforts greatly. Thereby the State will more freely, powerfully, and effectively do all those things that belong to it alone because it alone can do them: directing, watching, urging, restraining, as occasion requires and necessity demands. Therefore, those in power should be sure that the more perfectly a graduated order is kept among the various associations, in observance of the principle of "subsidiary function", the stronger social authority and effectiveness will be the happier and more prosperous the condition of the State' (Quadregesimo Anno 1931 paras79-80).

Consequently Catholic social philosophy, which was equally uncomfortable with both the ideologies of totalitarianism as it was with those of extreme individualism, 'came to be predicated on the concept of subsidiarity during the 20th century which was profoundly anti-statist' (Powell & Guerin 1997, p.73). Fouarge (2004) explicates the dual character of the principle of subsidiarity which has both positive and negative dimensions, from the perspective of economic doctrine, and from that of social doctrine, however he points out that there is a link between the principle of subsidiarity and the principle of solidarity. He concludes that it means two things: 'that the State should refrain from doing what individuals and the market can do better and that it should not refrain from doing what it can do better' (p.30).

The consequence of the strength of this principle for Ireland's health and welfare system was that there was little expectation that interventions would be imagined, organised, coordinated or delivered by the state. On the contrary, local level interventions at a subsidiary level grew and became relied upon to provide any required service and even then, only when the family were deemed unable to do so.

> '…the principle of 'subsidiarity' underscores the fact that the state will only interfere when the family's capacity to service its members is exhausted. The consequence for corporatist regimes was that hierarchical status-distinctive social insurance cemented middle class loyalty to a peculiar type of welfare state' (Adshead & Millar 2003, p.2).

It is out of this climate of corporate subsidiarity that organisations like the voluntary hospitals, a strong reliance on local charities and later the Voluntary Health Insurance Scheme grew to become as depended upon as a social democratic welfare state might be and, more recently, to become subsidised with subsidiarity as a key organising principle.

Subsidisation

The modes and mechanisms of subsidisation in the realm of Irish social life are multiple, are elusive due to their subtlety and can be seen to align to class lines. For example, a citizen investing in a private pension can seek to receive generous tax rebates for this investment. Similarly, those paying privately for doctors' fees and private consultancies may also claim a proportion of these medical expenses back against their tax. Housing provision is another example; those seeking decent housing for their family might be lucky enough to receive a rent allowance and must then seek their accommodation needs through private minimally regulated interactions. The landlords might also have received generous tax breaks. Private education similarly attracts generous tax refunds. Elderly care provision is another domain that in which the hand of the market is less than invisible. In response to the growing need to care for our elderly citizens, private providers have received very generous tax breaks to build and set up elderly care facilities throughout the country. Their residents, elderly citizens with life histories of paying high taxes, are often forced to sell their homes to fund their care at the end of their lives. This situation has emerged not just as a blip in recent years, and not merely because of the growing elderly population (that is often referred to as something of an inconvenience in regular discourse), but after a sustained strategy of neglect of elderly care needs in Ireland that can be clearly linked to the principle of subsidiarity as discussed earlier. Timonen and Doyle explain the history of the situation for elderly people stating:

> 'The rise of the private home care sector over the last decade is a highly significant development that has its origins both in the limited funding made available to the public and non-profit sectors and in the increased emphasis on cash-for-care where public funds are

> used to purchase home care services from private companies' (Timonen & Doyle 2008, p.84)

These examples serve to demonstrate the systematic nature of individualisation in Irish social life and in Irish social policy. Government policy can be seen to be systematically active in the transformation of citizens into consumers. Policy makers provide persuasive argument that enabling market forces and competition is preferable to an appropriately sustaining welfare state, which is instead ridiculed as a 'nanny state'. As Giroux (2011) clearly puts it, 'The social state is portrayed as a 'nanny' and those who partake in its services are represented as childish, lazy, and lacking any sense of individual responsibility' (p.597).

While the examples given above are useful and illustrative, they still do not help us to explain the phenomenon. Chapter 3 will help further in this regard and will allow some analysis of Ireland's health and welfare regimes within the context of key economic and ideological forces. Ireland's welfare state is clearly a highly contested field that has manifested as a consequence of historical, political and cultural factors. It can be accurately described as a fragile and underdeveloped system that is perhaps more accurately defined by its deficiencies than by its strengths.

Neoliberalism, the welfare state and Ireland

The current advancing neoliberal ideology advocates the primacy of the market and accentuates individual responsibility. Such a move away from the notion of collective, societal responsibility devalues levels of altruism inherent in a universal welfare state and its policies. Swank (2001) argues that states are not mere spectators to welfare reform as a result of neoliberalism, but instead he argues '…democratic political institutions determine the depth and character of welfare state restructuring' and they 'shape the degree to which domestic and international pressures are translated into neoliberal policy reforms' (p.198). This positioning of policy makers as proactive in the face of neoliberalism counters the prevailing depiction of neoliberalism as an unstoppable force that policy makers can do little about.

Recent events in Ireland's economic circumstances must be acknowledged as having influenced the condition of the welfare state. The short-lived appearance of an economic boom, the 'Celtic Tiger', reversed Ireland's trend of youth emigration

and instead resulted in an influx of migrant workers to Ireland. Irish citizens, who were less prepared to work for poorer wages, left many low-paid jobs to the erroneously titled 'non-nationals'. Greed and hysteria possessed the housing market with some ordinary middle class citizens turning into self-styled property developers both in Ireland and abroad. The drive to buy property, coupled with governmental policy choices, resulted in massively incentivised private home ownership, which facilitated a near-total neglect of public housing provision. Many of the first time buyers now find themselves in negative equity, living in unfinished suburbanised ghost estates, with minimal social facilities, a mortgage that necessitates two salaries and the associated commuting and childcare costs. Meanwhile, most of the banks that lent irresponsibly to 'investors' have been kept afloat on the back of intervention from the Troika and the subsequent loss of Ireland's economic sovereignty, massive tax increases for Irish citizens (but not the massive multinationals that enjoy low rates of corporation tax), pay cuts across all public sectors, social charges and pension levies. Cuts in social spending such as the blind person's pension, children's allowance, unemployment benefit and others are testament to significant welfare retrenchment in Ireland.

Many migrant workers have since left Ireland and the trend in emigration of the country's well-educated youth has once again returned. Many families from EU accession states have settled in Ireland however, and remain the subject of thinly veiled racism in the discourse on Irish airwaves and in certain sections of printed media, much of which references disentitlements to welfare. Such discourse of deservedness is strikingly influential in terms of the public understanding of issues of recognition, rights, entitlements and obligations but it is also enormously telling. Of course, the discourse surrounding an issue as emotive as public welfare can be used to the advantage of government in their own communications, particularly at times of reform. Mau & Veghte (2007) point to research indicating that:

> 'A country's welfare reforms depend not only on its political economy, institutions, and policy responses but also on politics, that is, on the government's ability to gain public approval for reform through discourse' (p.9).

Fraser (1989a) describes talk about people's needs as a particular type of political discourse suggesting '…needs-talk appears as a site of struggle where groups with unequal discursive (and nondiscursive) resources compete to establish as hegemonic their respective interpretations of legitimate social needs' (p.296). Here Fraser is acknowledging the unequal power that resides in those that identify needs of citizens, and thereby create policy around them, when compared with the meagre power possessed by those actually in need themselves and thereby truly aware of need.

Returning to the issue of public perception of issues such as welfare reform, Soss & Schram (2006), for example, rather cynically suggest that the initiatives that governments pursue are not just 'efforts to achieve expressed social and economic goals, but also as forms of political action designed to enhance particular actors' abilities to achieve long-term political goals' (p.17). They go on to examine public opinion on welfare reform and identify a number of interesting findings in their US study. Firstly, the visibility of a policy or policy change is highly significant and that changes will only be noticed if they directly affect peoples' lives. Further, they found that many welfare policies have relevance more as symbolic reflections of the country's values than they do in terms of their actual benefit. The American people in this study also distinguished strongly between policies that reward work from those that compel work, and in the same vein, this sample firmly delineated between the 'deserving' and the 'undeserving' poor. Identifying that the way policies are reported in mass media and by elite rhetoric are of great importance, Soss and Schram (2006) go on to emphasise that:

> 'The crucial point is that mass perceptions of public policies depend upon both a policy's internal characteristics and its positioning within the larger structure of a policy regime' (p.22).

Van Oorschot's (2006) study of the public perceptions of the relative deservingness of elderly, sick, unemployed and immigrants, found that European citizens share a common understanding of deservingness. His study indicated a relationship between conditionality and the wealth of the state and levels of trust. An earlier study by the same author identified five deservingness criteria; control over neediness, level of

need, identity, attitude and reciprocity, with control featuring as the most important. Other findings indicated that migrants were seen as the least deserving group of needy people. Related findings have been reported in US studies of perceptions of deservedness and loyalty:

> 'In household surveys, support for welfare among white Americans is influenced by the race of the poor people who live around them: if their neighbours are white they are more inclined to generosity than if their neighbours are African-American' (McKee & Stuckler 2011 p. d7973).

So public perceptions around issues like welfare and social supports are influenced by perceptions of deservedness and by the actual visibility of need. Welfare policy decisions are made, therefore, with the interpretations of the electorate's views and opinions in mind. Governments must gauge the public's perceptions in relation to welfare entitlements and levels of deservedness. However, the distinction between deserving and undeserving is a perception that has perpetuated societal thinking for centuries, and is only likely to become more ingrained in public perceptions with the advances of neoliberalism and market, as well as moral, discipline (Garland 2002). It is an effortless task, then, for governments to exploit such perceptions, and to make policy reforms that retrench expenditure on welfare entitlements to such groups, while engaging in a discourse that is seen to appeal to the needs of the electorate.

Neoliberal retrenchment of the Welfare State

The role of the welfare state as a redistributive machinery that protects the citizenry from the social risks associated with ill health, unemployment and disability in a capitalist state is a much-contested one. The original intentions of Beveridge, described as the 'midwife of the welfare state' (Bauman, 2005), was that the welfare state would provide cradle-to-grave assistance to citizens and protection from the inherent risks of the market society. It is intended therefore that the provisions provided would go some way towards correcting inequalities created by the market. The influential work of Richard Wilkinson (2009) and his colleagues has demonstrated that when countries strive towards egalitarian policy, most

successfully through redistributive strategies, there are better outcomes for everyone in that society. The welfare state and redistributive policies have been shown, by some, to have improved the health of their populations, for example (Navarro 2008). Others however, have sought to question these findings, suggesting that health outcomes and related policy decisions are difficult to disentangle and fail to enjoy a causal relationship (Granados 2010).

Critique of the welfare state is not without its own ideology. Since the era of Thatcher and Reagan a significant turn can be seen to have emerged in many liberal western societies in the sense of a greater level of surveillance accompanied by concerned cries of the risk of welfare reliance. Referred to by many as a 'disciplinary turn' (Schram et al. 2009) welfare provisions in liberal states in the west can be seen to emphasise issues of responsibilities over rights, and to promote the private over the public, leading to a less caring and more controlling focus. The alternative offering, 'social inclusion' succeeds only in the oppression and criminalising of the poor and vulnerable. Garland (2002) describing the policy coherence of the Thatcher and Reagan governments as 'thematic unity' (p.98) identifies their mutual aim of discrediting and undoing the policies of their respective welfare states.

> 'Reversing the solidaristic solutions of the welfare state, with its concern for social equality, social security, and social justice, the new neo-liberal politics insisted on market fundamentalism and an unquestioning faith in the value of competition, enterprise, and incentives, as well as in the salutary effects of inequality and exposure to risk' (Garland, 2002, p.99).

Policies appropriate to this ideological position resulted in a widening of inequities, a strengthening of the rich and a weakening of the collective. So as to stem the flow of provisions from welfare states, restrictive qualifying terms and exacting surveillance methods have been introduced.

Reliance & surveillance

Those supporting welfare retrenchment are often heard to express concern that recipients may become dependent and entirely reliant on the welfare state. This

argument, reminiscent of out-dated beliefs surrounding the use of opiates to control pain, seems to suggest that the excruciating alternative of falling right through an absent social safety net is somehow preferable. The mantra of dependency is often heard alongside opportunities for 'social inclusion'. These provide the welfare reformists with rationale to create a tightly means-tested, highly monitored, stigmatising and retrenched welfare state; certainly more disciplinarian than emancipatory. Munger (2003) describes well the implications of the term dependency as setting the recipient apart from the mainstream; 'The term implies reliance on the collective resources of the community and, more negatively, a moral failure to become self-sufficient' (p.662).

Extraordinary levels of surveillance have also been characteristic of the contemporary welfare state in Ireland. Stringent measures for means testing are currently in place for all applicants for Social Assistance payments, Jobseekers' Allowance, the Medical Card, Disability Allowance, the Blind Pension, a Motorised Transport grant, the Mobility Aids grant scheme and there are currently plans to introduce means tests for the travel pass for older people (Ring 1998). Policy makers have also passed on responsibility for surveillance to the public. For example, the website of what was previously known as the Department of Social Welfare (now renamed the Department of Social Protection) appeals to members of the public to report welfare fraud anonymously via an online form (Social Protection 2010).

Government and its agencies announce proudly their efforts to 'clamp down' on welfare fraud, with target savings announced in advance. Meanwhile, applicants face long delays and must negotiate bureaucratic obstacles, as well as high refusal rates; for example, 54% of those applying for the Disability Allowance in 2010 were turned down. An effort to 'crackdown on welfare fraud' by the then Social and Family Affairs Minister in 2008 were found to violate EU Law that allows EU state citizens to move to another member state to seek work, while continuing to receive unemployment benefit in another state. In a post-budget press conference in October 2013 the minister Joan Burton announced that Gardaí would be drafted in to man checkpoints at industrial estates and airports to catch welfare fraudsters who 'are claiming benefits, are actually in fact going off to work either self employed or working and not declaring it' (Duncan 2013). Against the backdrop of a failure to hold those

responsible for the country's banking and fiscal crisis to account, such measures are greeted cynically by many. However, many others are sufficiently distracted by the alarmist narrative of an 'other' who is to be blamed for the economic difficulties and labelled as a miscreant. This narrative of blame, punishment and criminality in relation to welfare is described in Wacquant's example of US welfare 'reform' by (2009) as when:

> 'The penal revamping of welfare emerges as a core component of the new state apparatus joining workfare and prisonfare into a single institutional mesh entrusted with the double regulation of poverty on the work and crime fronts' (p.108).

Examples of such constraining and regimented application of social policies can be seen to have taken effect in many countries. For example, Henman & Marston (2008) reported on levels of rigorous and intrusive surveillance contributing to categorising, stratifying and thus further dividing Australian society:

> 'Quite clearly, professional classes are able to enjoy the benefits of the welfare state, enjoying a form of "regulated freedom", while those outside or at the bottom end of the labour market or the housing market are subject to a range of intrusive screening instruments' (p.200).

Further, Henman & Marston cite Cooke (1989) who points out that in the UK there are far more opportunities for middle and higher classes to defraud by way of tax avoidance with far less scrutiny than is given to alleged 'welfare fraudsters'. The injustice of such a situation can similarly be seen in Ireland, whose economy has been severely damaged by what could be defined as political and economic fraud, while providing tax breaks to developers and the super rich.

Workfare & Activation

The notion of mere provision of benefits without anything in return has been questioned by neoliberals, as well as by other critics of the welfare state. A number

of instruments have been exploited that seek to force the recipient into the labour market, a process referred to as 'activation' of welfare recipients. Under Nixon, the US welfare state was the first to introduce 'Workfare' as a means of breaking the welfare-poverty cycle, that is, offering welfare in return for work or work related training. While this welfare to work strategy was endorsed in the Thatcher and Reagan eras, it can be seen to have grown in popularity under subsequent administrations. Peck & Theodore (2000) in their critical analysis of 'welfare to work' programmes in the US and the UK warn of the destabilising effect it is likely to have by emphasising the substitutability of workers and their labour:

> 'Perversely, then, 'work first' may achieve its short-term employment goals of raising employment rates for designated groups at the expense of long-run job security, or indeed by detaching other groups of workers from waged employment' (p.128).

This thesis of a destabilising effect is also supported by findings in Canadian workfare policy research (MacPhail & Bowles 2008). Here, findings indicate a higher likelihood of workers in British Columbia finding themselves in temporary insecure positions after the implementation of conservative neoliberal work policy reforms.
Ireland has implemented a similar activating approach to 'workfarism' through the government's 'Work Placement Programme'. Through this scheme jobseekers can be placed in businesses for up to 9 months to gain experience and skills while receiving only their unemployment benefit. Payments can be withheld if recipients do not agree to participate. Powell & Guerin (1997) warn of the criminalisation of poverty and caution that: '…workfare in its classical form […] replaces the right to welfare and defines the claimant as a miscreant who must be punished rather than helped' (p.59).

Examining workfare type strategies, Handler (2009) identifies possible policy convergence between US and Western European welfare states that includes '…conditional welfare with targeting, sanctions…' (p.88). He concludes that economic decline is the most significant factor influencing the introduction of such retrenching policies. The impact of sustained retrenchment can be seen to have hit

hardest in the poorer and marginal portions of society in the US (Wacquant 2008) resulting in the ghettoization of whole strata of the poor in marginalised communities. Furthermore, the parallel developments of the US criminal justice system and welfare reform have been noted to have 'an eerie similarity' (Wacquant 2009). Global similarities of policy approaches can be traced to policy prescription coming from powerful bodies such as the OECD and the IMF.

The move to make welfare contingent on performing contingent work must be seen for what it is; a means of re-joining workhouse principles that equate unemployment with delinquency, while at the same time providing the labour market with cheap unsecure labour. Forced 'activation' into the workforce and the increasing use of punitive measures against those on the margins of society, result in less of a welfare state and instead a citizenry experiencing life in a garrison state (Giroux 2002). For these reasons workfare or activation initiatives are a threat to the welfare state and endorse the disciplinary perception that must be felt by those reliant on the limited income it provides.

Irish Attitudes to Welfare State

The acquiescence referred to in this thesis towards the diminished and limited role for the state in the provision of health and welfare should be understood within the context of overall social attitudes to welfare. Peillon (1995) reported that there was 'striking popular support for the welfare state in Ireland' (p.3), while more recent studies have reported similar findings, with welfare state legitimacy in Ireland appearing higher than in the UK and more social democratic welfare state countries (Payne & McCashin 2005). Social attitudes to welfare are shaped by economic and political circumstances, among others, and are closely related to attitudes to broader issues such as inequality, poverty and wealth. Hardiman et al (2006) point to a continuum between individualist attitudes and societal attitudes to poverty and wealth in findings they derive from the Irish Social and Political Attitudes Survey (ISPAS) carried out in 2002. Those with a strong individualist attitude, for example, believe:

> '…that individuals effectively determine whether they are rich or poor, according to how hard they work, how much talent they have and so on' (Hardiman et al, 2006 p. 53)

Whereas, those holding a strongly societal view believe:

> '…that the possibility of becoming wealthy or poor is largely determined by social structures and institutions, that the well off have been doing better, and that starting out with money and connections is important' (p. 54).

They conclude that while Irish citizens generally tend towards supporting an individualistic interpretation, there is also substantial support for the societal perspective, as well as a substantial cluster (about one-third) that take a mixed position. In the context of these findings it is not surprising that Irish citizens have not successfully challenged health and welfare policies that shift responsibility from the state to the individual.

The legitimacy of the welfare state in Ireland would appear, therefore, to rely on the strong support of only about a third of the citizens, and a mixed, less committed support from another third of the population. In his examination of welfare in Ireland, Peillon (2001) refers to the concept of legitimacy as 'the capacity of a socio-political system to produce and maintain acquiescence from the citizens of the nation-state' (p. 44). He goes on to point out that:

> 'The concept of legitimacy applies only when consent and acquiescence rest on a belief in the adequacy and fairness of established political institutions. In this sense, legitimacy points toward the beliefs according to which the authority of the central power is justified in the eyes of those who are subjected to it' (p. 44).

Such a belief in the fairness of institutions, such as the welfare state, can be examined through surveys of attitudes such as the European Social Survey (ESS), which allows some comparison across countries. The 2008 examination of welfare attitudes in Europe, for example, positions Ireland in the lower one third of countries in Europe in terms of the public's level of satisfaction with welfare state performance

(Svallfors 2008). One of the indicators for this item specifically asked about satisfaction with health services, wherein Ireland scored even lower. The countries that recorded lower levels of satisfaction with health services than Ireland were Romania, Hungary, Poland, Russia, Latvia, Greece, Bulgaria and Ukraine.

Comparison between European countries is particularly useful when policy makers look to neighbouring examples of social institutions. The 'Nordic model' is frequently cited as an admirable target for which policy makers should aim. One of the neoliberal criticisms of a strong welfare state, such as that seen in Scandinavian states, has often claimed that government interventions may serve to stifle spontaneous human acts of solidarity because:

> '…formal government provision "crowds out" individual acts of social support because people step aside and leave things to the state' (ESS 2008, p.3).

However, Van der Meer et al's (2008) findings, using ESS data, do not support this assumption as they report that:

> 'Higher social security spending does not diminish individual acts of social support. There is no evidence for the notion that the welfare state "crowds out" social solidarity. The higher the average income in a country, so the more inclined are its citizens to provide for one another. Economic security strengthens rather than weakens social ties' (ESS 2008, p.3)

Higher levels of social spending and consequent reduction of income gaps, therefore, do not impinge on spontaneous solidaristic behaviours. Such intervention by the state, however, remains counter to the core principles of classical liberalism and its descendant, neoliberalism. Neoliberalism of course prefers the state not to intervene as it claims that if we are left unrestricted by state intervention we will be driven by self-interest to innovate and this ultimately leads to growth and enhanced overall welfare (Monbiot 2014).

Related to this, a further central criticism of welfarism, which is reflected in attitudes to the welfare state, relates to issues of cost. It is this aspect that lies at the centre of retrenchment efforts and most acutely felt at times of economic difficulties. The recent economic crisis has resulted in a growing perception of a high cost associated with the welfare state often with some misconceptions. Considine and Dukelow (2012) indicate that issues of cost containment within welfare spending and the economic crisis have become confused.

> 'The predominant discourse on the crisis […] tends to conflate the fiscal crisis with profligate public spending, leading to a perception that the welfare state is of itself part of the problem' (Considine & Dukelow 2012, pp.261-2).

Alongside these suggestions of blame, issues of deservedness and merit then arise within discussions of cost, including questions that ask whether services are delivering good value while remaining aligned to principles of distributive justice. It can be deduced therefore that levels of support for the welfare state are likely to fall, or at least slide towards the individualist end of the spectrum to which Hardiman et al (2006) refer, if citizens are subjected to a discourse of 'welfare fraud' wherein costly redistributionary measures are reported as being wasted on the less deserving.

Even before the economic crisis, though, Irish attitudes to welfare were reported to be changing. Payne and McCashin (2005) for example tentatively suggest that as a result of Ireland's period of economic prosperity 'a liberal-individualist element has taken root in Irish public attitudes' (p.16), and their analysis suggest 'an institutionalized acceptance of some processes that sustain marked inequality' (p.16). These suggestions are supported by Delaney & O'Toole's (2006) findings in their examination of preferences for social welfare expenditure in Ireland, wherein they referred to evidence of the perspective of self-interested economics as a strong feature among the respondents to their survey. Halman et al (2008) make reference to similar tendencies to self-concern and relates this to attitudes, stating:

> 'Increasingly, people's actions and behaviors are rooted in and legitimized by people's own personal preferences, convictions and goals. The endeavor to pursue private needs and aspirations is said to result in assigning highest priority to personal need fulfilment and self expression. Self-development and personal happiness have become the ultimate criteria for individual actions and attitudes' (p.5)

A recurring theme across these different aspects of attitudes to welfare is that of consensus and legitimacy. Governments hope to craft their social policies in a manner with which the electorate agree and generally resist highly unpopular moves. Welfare retrenchment, for example, may be assumed to result in voter dissatisfaction. Considine and Dukelow (2012), however, indicate that this may not always be the case and they point to the importance of how such retrenchment is framed.

> 'Ideas about the generosity of the welfare system, welfare as a lifestyle choice, welfare fraud, the disincentive effects of welfare and the inefficiency of the public sector making it not for purpose have become commonplace and relatively uncontested in current political debate' (p. 269).

They refer to Giger and Nelson (2010) who suggest that retrenchment is not always unpopular among voters. They even go so far as to suggest that governments:

> '…might not only lose but also win votes for retrenching. As such our analysis challenges both the notion that retrenchment is an unpopular policy choice …' (Giger & Nelson 2010, p.2).

Some voters, it would appear, encourage and reward welfare retrenchment. Again, this returns to the issue of public attitudes to welfare and to conceptions of deservedness. Handler and Hasenfeld (1991), with terminology that is reminiscent of Poor Law times, remind us that:

> 'Social welfare policy cannot be fully understood without recognizing that it is fundamentally a set of symbols that try to differentiate between the deserving and undeserving poor' (p.11).

While welfare state legitimacy becomes increasingly challenged, alternative strategies to a strong welfare state continue to gain legitimacy and a stronger role for private sector actors is promoted. The popularity of such strategies should also be seen within the context of the historical and political legacy within Ireland, as well as the cultural backdrop. Irish political culture is often criticised as clientelistic and concerned with parochial imperatives (Kitchin et al. 2012; O'Carroll 2002; TASC & Democratic Dialogue 2005; Mair 1992). Mair (1992) for example, refers to clientelism in his attempt to explain the absence of class politics and the presence of individualism that is characteristic of Irish politics:

> 'Unlike in other political systems […] where organised mass parties mobilise collective identities among voters, Irish politics is characterised by a pattern of individualistic mobilisation which is inimical to the pursuit of collective interests' (p.395).

However, he does not believe that clientelism in itself explains all of Ireland's political peculiarities, believing that:

> '…the pervasiveness and exclusiveness of clientelistic links and particularistic ties has tended to be overestimated, as has the degree of individualistic mobilisation; while the importance of party, and hence of more collective mobilisation, has correspondingly tended to be underestimated' (Mair 1992, p.395).

Mair is not alone in his scepticism regarding the impact of clientelism, however, with other writers suggesting that it is not as pervasive as it may have been in the past. Delany et al (2010) for example, in their experimental research analysing parliamentary questions found little evidence of a strong culture of clientelism within that dataset. Similarly, but more definitively, Gallagher and Komito (2010) argued that:

> 'the word "clientelism" is simply not appropriate to describe what TDs do in their role as constituency representatives. It is more realistic to see TDs as being engaged in "brokerage", a distinct concept' (p. 243).

It may be that globalisation and the Europeanisation of Irish politics has resulted in fewer residual clientelistic features. Wood and Gough (2006) welcome such de-clientelization as it protects the people from the negative effects of a market economy and formalises rights to security.

Conclusion – What future for the welfare state?

The welfare state has been subjected to much critique from many camps, indeed it is said by some, to be at the centre of much controversy (Bauman, 2005). But what is the future of the welfare state? Will it survive the onslaught of reform that is armed by neoliberal and market hegemony? Lichter & Jayakody (2002), while acknowledging that there is no place for complacency, argue that welfare reform in the US, for example, was not as disastrous as had been predicted by some. Pierson (2006) however, argues that despite numerous knocks to the welfare state (globalization, societal ageing, new social risks) none have proven catastrophic and it will survive. Indeed, it is suggested by some that the welfare state will survive because capitalism cannot function without it. Offe (2007), for example, refers to the failure of conservative critics to 'demonstrate that advanced capitalism minus the welfare state would actually be a workable model' (p.71). Suggesting that capitalism can neither co-exist with, nor exist without, the welfare state, Offe refers to this as the 'embarrassing secret of the welfare state' (p.71). The National Economic and Social Council's Report on Ireland's Developmental Welfare State makes a similar association between a successful economy and a successful society, referring to these as moral and functional requirements (NESC 2005). Others go further still referring to an irreversibility thesis, which argues that the welfare state is, an 'irreversible major institution of advanced capitalist countries' (Therborn & Roebroek 1986, p.319).

Esping-Andersen's typologies of welfare regimes, while highly criticised, remains an important offering in terms of its use of decommodification as an instrument of

typology. In the decades since the publication of Three Worlds the position of capital has become more central in the minds of government policy makers and in that of the contributing taxpayers. With the increasing strength of neoliberalism and market dominance, the degree to which citizens receive support that enables them to remain outside of the labour force becomes increasingly important; hence the remaining relevance of decommodification as a significant index.

Arguably, the most destructive consequence of market dominance and the associated 'Celtic tiger' boom years in Ireland is the erosion of the principles of altruism and solidarity. This erosion has been fuelled by the driving influences of subsidiarity, privatism and individualism across all areas of the social world. These circumstances, a combination of political and economic deficiencies and the strength of Catholic social teaching in relation to subsidiarity, merged to prevent the emergence of a fully fledged welfare state in Ireland. Meanwhile the residual trace of the welfare state is transformed from a core social institution of support into a disciplinary instrument that leaves citizens subject to it with a sense of isolation and vulnerability, to be driven by a deep need for a mutually supportive system of association, into finding security in club-like settings.

It is essential that good public policy that strengthens social solidarity is designed, framed and communicated to Irish citizens in a manner that disregards status issues, yet is aware of issues of race and gender. Such a reinvention requires a new form of social contract to be established whereby welfare retrenchment and surveillance are withheld while the citizenry engage in a commitment to social solidarity. A welfare state wherein all social actors embrace altruism as it is defined in the seminal work of Richard Titmuss is a potential remedy to the currently individualised society that is symptomatic of a retrenched welfare state in neoliberal capitalist countries.

Ireland is among the most unequal societies in the developed world (TASC 2010), and its welfare state has much ground to make up in terms of correcting these inequalities. It would appear that whilst remaining ideologically disparate, Ireland's 'hybrid' welfare state model and capitalism have much shared history and potentially a shared future. But modern capitalism is not of the same hue as that of previous decades when the basis of classical liberalism was formed. The current neoliberal

sovereignty in western democracies, with its focus on protection of the market and the private corporation, precipitates specific threats to the welfare state. These threats manifest in the form of policies of surveillance, stigmatisation, stratification, retrenchment and disciplinary gestures of 'the iron fist in a velvet glove'.

An examination of this process of neoliberal growth, and its origins in classical liberalism, will be provided in Chapter 3 and the manner in which the neoliberal economic order has become hegemonic will serve as explanatory in order to understand the current condition of Ireland's health care system and welfare state.

Chapter 3: Neoliberalism: Culture of the Private versus the Culture of the Social

Introduction

This chapter will examine the evident dominance of individualism within Irish society and social policies, reflecting an increasing hostility towards collective social values. While it could be argued that such values have never featured strongly in the Irish case, the basis on which a social and cultural shift has evolved, in response to global neoliberal trends, will be discussed in terms of social policy development, economic policy and visible social consequences. The principles of neoliberalism and the resulting impact on levels of social solidarity will be discussed in this chapter. However, also of significance here is the origin of the entire neoliberal ideology and the degree to which these remain related to classical liberal ideas. This chapter will map the origins of classical liberalism, focusing on the core tenets and will trace the progress of liberalism through to contemporary neoliberal ideology.

Ideological concepts, and the manner in which they can become distorted, are of importance because of their potential to influence normative valuations with regard to the significance of concepts like solidarity as social phenomena. They also relate very directly to the research question of this thesis, in that, an analysis of these concepts will enable an explication of the values that underpin the health and welfare regimes experienced in Ireland. A primary example of a society's regard for values such as solidarity and collectivism is illustrated in the nature and breadth of its health and welfare system. For this reason this chapter will examine how an unequal system of health, as part of a commodified welfare system, comes to be tolerated with what can only be assumed to be a level of acquiescence and with little or no public dissent. The health care system of any country is a useful gauge, as Adshead and Millar (2003) agree:

> 'not only because of its central importance to studies of the welfare state, but also since health policy is in many ways a key indicator for

> other welfare issues. The health of the population is not just about a good health service but dependent on a myriad of factors such as housing, sanitation, working conditions, environmental pollution, education, unemployment and the general economic conditions of the country' (p.2).

What is also relevant to ask here is, how it is that the driving force of neoliberalism would appear to have the power to influence collective thinking within a society to such an extent as to enable policy decisions to be enacted regardless of their unjust consequences? This question is not unlike that asked by Harvey (2007) in relation to inequalities resulting from neoliberalism, when he asks; 'How is it, then, that "the rest of us" have so easily acquiesced in this state of affairs?' (p.38). This chapter will seek to explore the answers to these questions, particularly the identification of the conditions of origin in the past that allowed this present to evolve.

Classical Liberalism

In order to understand the influence of neoliberalism it is important to first trace the origins of the ideology, which it claims to propagate. Furthermore, it is useful to examine the extent to which what is currently termed as 'liberalism' or neoliberalism bears resemblances to, or is even informed by, what is understood as classical liberalism. Political thought surrounding original or classical liberalism can be traced through the period of the Enlightenment and in the work of significant 17th, 18th and 19th century writers, philosophers and political theorists.

In the 17th century, having been an interminable witness to war for most of his adult life, Thomas Hobbes tended to fear anarchy, leading him to believe strongly in the importance of civil government, to the extent that humans abrogate many of their rights in favour of being governed. His conception of the state of nature as being a hazardous unstable set of circumstances was widely held throughout the middle ages. Man could not be trusted to do anything other than act to his own advantage and in an ungoverned state, as described in Leviathan (1651), Hobbes warned of anarchy and war of 'all against all' in a nasty, short and brutish life. John Locke, however, was less convinced of a preference for government over the state of

nature, which he regarded as more stable than that imagined by Hobbes. His conception of the state of nature was more reasoned:

> 'Men living together according to reason, without a common superior on earth, with authority to judge between them, is properly the state of nature' (Locke 1689, p.140).

In The Two Treatises of Government (1689) Locke challenged the authority of legitimate government, particularly rejecting the hereditary principle in politics, opposing authoritarianism, and favouring instead the recognition of inalienable natural rights. Often referred to as the father of classical liberalism, Locke argued for a separation of church and state and was in favour of religious tolerance. Such was his influence on liberalism that phrases included in the American Declaration of Independence, for example, those referring to 'life, liberty and pursuit of happiness' are attributed to Locke (Gerber 1996). Russell (1946) emphasises that little of Locke's thinking in terms of a theory of government is entirely original and that his view on the state of nature and natural law had been adopted from his predecessors. He makes reference to more modern conceptions of liberalism when he says that Locke's view of the state:

> '…cannot be freed from its theological basis; where it survives without this, *as in much modern liberalism*, it is destitute of clear logical foundation' (p.569)

Here Russell makes two points; firstly that consideration of the historical and theological foundations of ideas is central to them being fully understood, and secondly that more modern conceptions of the ideology of liberalism would appear to have lost their relationship with classical liberalism's core tenets. It should be noted though, that Russell was writing in post-war Britain when the agenda of collectivism was strong and the cause of classical liberalism had become marginalised, having yet to enjoy a resurgence in popularity.

Less than a century after Locke, in 1776, Adam Smith's 'Wealth of Nations' attacked the established protectionist managed and controlled mercantile system, and called

instead for free trade. He argued that government should not interfere in commercial activities. In book IV for example he says:

> 'The statesman who should attempt to direct private people in what manner they ought to employ their capitals, would not only load himself with a most unnecessary attention, but assume an authority which could safely be trusted, not only to no single person, but to no council or senate whatever, and which would nowhere be so dangerous as in the hands of a man who had folly and presumption enough to fancy himself fit to exercise it.

(Book IV, Chapter II, p. 456, para. 10)

Smith does not appear to trust those in power whom, by virtue of their arrogant assumption of an ability to manage a marketised society, have rendered themselves instantly ineligible to do so.

Related to the concepts of a less involved government and the promotion of free trade is another key feature of classical liberal thinking; Individualism. This idea promotes the prominence of the individual and individualism in place of a collective viewpoint. Adam Smith stated: 'Every man...is left perfectly free to pursue his own interest in his own way…' (Smith 1993, p.391) and likely intended this and other comments to be regarded as statements of egalitarianism rather than statements of egoism or atomism. This central concept of the individual relates closely to the modern conceptions of personal choice and liberty, but the current understandings of these concepts have become distorted to become closer to "every man for himself" than "each entitled to their liberty". The freedom to pursue own interests requires a less interventionist state that allows the evolution of spontaneous or unplanned order. The market, according to classical liberal thinking, was engendered with the ability to enable such order only when it was free and unfettered but with the correct institutions and rules in place. The potential of 'spontaneous order' as the invisible hand of the market is attributed to Adam Smith and refers to '…the production of benign unintended consequences which manifest themselves in spontaneous order'

(Smith 2006, p.14). Spontaneous order arguments typify classical liberalism and maintain that society is advantaged when left to order itself:

> 'The invisible hand is to be found in those social practices and institutions that have evolved by a process of unintended consequences in such a manner as to facilitate beneficial social outcomes' (Smith 2006, p.172).

Adam Smith was of the belief that such order would be achieved only under conditions of perfect liberty without coercion, and that this would inevitably lead to perfect equality.

It is the balance of the authority of the state with the liberty of its citizens that was of concern to the influential philosopher John Stuart Mill in the 19th Century when he wrote his utilitarian essay 'On Liberty'. He argued for a significant degree of freedom of the individual, while ensuring the wellbeing of others, saying:

> '…the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others' (Mill 1859, p.18).

Mill's often-misinterpreted argument is essentially one that argues against repression, but it also warns that man needs to be protected from himself (Honderich 1974). Mill cannot be seen to be calling for a complete absence of state intervention, on the contrary he appears to regard the state to have an essential role in protection of its citizens. In Chapter 3 for example he states:

> 'Acts of whatever kind, which, without justifiable cause, do harm to others, may be, and in the more important cases absolutely require to be, controlled by the unfavorable sentiments, and, when needful,

> by the active interference of mankind. The liberty of the individual must be thus far limited; he must not make himself a nuisance to other people' (p.65).

In a later publication, Consideration on Representative Government (1861), Mill develops a utilitarian understanding of Smith's market society (Turner 2008) however he sets out some suggested boundaries of state involvement that, when examined closely and beyond the initial phraseology, would appear to be very far from 'light touch regulation':

> '…neither ought any branch of the executive to interfere with authority; but as an adviser and critic, an enforcer of the laws, and a denouncer to Parliament or the local constituencies, of conduct which it deems condemnable, the function of the executive are of the greatest possible value' (Mill 1861, p.292)

Advising, critiquing, enforcing and denouncing require considerable state involvement and rather more than an invisible hand. Mill's thoughts on the extent of state involvement would appear to differ from that of later liberal ideas and indeed that of what has come to be known as neoliberal thinking. Classical liberal thought as espoused by Mill undergoes something of a transformation before the emergence of neoliberalism later in the 20th Century. Mills' writing, as well as that of Smith, Locke and Hobbes begin to be interpreted in a very specific manner. For example, where Smith emphasised the importance of 'freedom' of every individual man, arguably an egalitarian preference, others sought to interpret this as meaning that each man should simply serve to improve his own individual circumstances for himself. Milton Friedman (Friedman & Friedman 1980) warns of self interest as the 'most basic instinct of all human beings' (p.144) and suggests that it is the very tendency of every man to better his condition that has resulted in what he claims is the failure any drive towards equality. Friedman seems to describe this as man's natural state and fails to invoke any suggestion of a role for the state in moderating this alleged verity, for to do so would be to impede the freedom of the individual which is of the utmost value.

A further but even earlier example of the development of classical liberal perspective is explained by Hayek when he gives the example of the movement that agitated for free trade and reform of the Corn Laws in Britain between 1820 and 1846:

> 'The movement […] took a somewhat more extreme laissez faire position than would have been required by the liberal principles of Adam Smith and the classical economists following him. Their predominant free trade position was combined with a strong anti-imperialist, anti-interventionist and anti-militarist attitude and an aversion to a expansion of governmental powers; (Hayek 1978, p.129)

So it can be seen that even as early as the 1800's classical liberal ideology was, while moving away from the principles of Smith, a constantly evolving set of ideas that adapted to the prevailing social and economic circumstances. As Turner (2008) puts it '…liberal ideas are seldom static and never uniform' (p. 47).

Within the 20th century differences of interpretations of liberal economic philosophy continued to emerge and competing schools of thought such as the Austrian school, the Freiburg school and the Chicago school of economics were established. During the 1940s three significant books that were to be very influential were published. The Road to Serfdom (1944) by Hayek, Bureaucracy (1944), by Ludwig von Mises, and The Open Society and Its Enemies (1945), by Karl Popper. Stedman Jones (2012) details how these texts articulated developments of prior thinking because they:

> 'were conceived in reaction to a political and economic landscape in the 1940s that was hostile to their views […] Each began to articulate a neoliberal alternative to discredited nineteenth-century laissez-faire economics, on the one hand, and New Deal liberalism and British social democracy on the other' (Stedman Jones 2012 p.33).

The political, economic and social landscape of the post-war era were hugely influential to the prevailing ideologies and policies:

> 'The "tempered capitalism" that emerged after 1945 was the product of a decade and a half of sustained political struggle, with total war, dynamic political leadership, and a powerful labour movement all playing a role in shaping the resulting social settlement' (Jackson 2012, p. 1256).

Despite numerous publications of the works of like-minded liberal thinkers at this time, their thinking was counter to the prevailing preference for collectivist approaches to government and as a result these intellectuals were isolated from mainstream thought, a problem recognised by Hayek:

> 'The remaining liberals in a collectivist world, he [Hayek] pointed out, were intellectually isolated within their own countries. Hayek therefore saw the need for an international society for "liberals", which would become the focal point of international efforts to repel the intellectual claims of collectivism and to encourage the "rebirth of liberalism"' (Turner 2008, p.69)

In 1947 a select group of academics, economists and students were invited by Professor Friedrick von Hayek to meet at Mont Pelerin in Switzerland, to discuss how they would renew the cause of liberalism and resist the dangers, as they saw them, of collectivism. What became known as The Mont Pelerin Society (MPS) sought to collectively and pro-actively engage in promoting liberal economic philosophy through think-tanks, education, academic publications and pamphlet production. Furthermore, the society recognised the need to acknowledge the defects of the market oriented economic system that had been relied upon up to this point:

> 'Hayek and others believed that classical liberalism had failed because of crippling conceptual flaws and that the only way to diagnose and rectify them was to withdraw into an intensive discussion group of similarly minded intellectuals' (Mirowski & Plehwe 2009, p.16).

In the interwar and immediate post-war periods there were significant drivers influencing the emergence of what came to be known as neoliberal economic ideologies. Particularly, philosophers and political economists were responding to fears of totalitarianism and communism, and were attempting to traverse a middle way between laissez faire economic strategy and more activist forms of liberal thought (Stedman Jones 2013). In this period efforts were made to return to the core principles of classical liberalism and the ideas of Locke, Hume and Smith. It was the establishment of the MPS that laid the groundwork for a substantial neoliberal movement and it 'marked a transition point from one phase of the history of neoliberalism to another' (Stedman Jones 2012, p.31). Hayek, and his like-minded colleagues felt the need to establish the MPS because of the social, economic and historical circumstances at that time. In this post war period the cause of liberalism had undergone severe damage and Hayek believed that classical liberalism in Europe and beyond was being pushed out by socialism and that it had fallen victim to historical revisionism:

> 'Hayek claimed that a particular historical interpretation, used as "propaganda", was responsible for some of these illiberal trends in the world. In particular, it was the direct influence of certain economic historians over public opinion that had partially led to the present discredited status of economic liberalism' (Turner 2008, p.48).

In launching their counterattack the liberals would need to not only be persuasive of the value of their ideas, but they would also need to discredit the account of the counter ideas of collectivism. In the decades that followed, with the backdrop of the post war era and later the cold war, belief and faith in neoliberalism among economists of influence grew stronger and the locus of the neoliberal campaign shifted from Europe to the US. Think-tanks and economic academia became central locations of intellectual and political efforts, in much the same way that the left had been successful in influencing intellectual elites in the past. At the University of Chicago's Economics Department Friedman, later Hayek and other like minded academics engaged in growing a robust body of evidence to support their beliefs in

free market ideology as a perfect scientific system, a process that was lent credence by their academic achievements (Stedman Jones 2012). The Chicago School, as it became known, also sought to inculcate in its students a faith in the fundamentals of ultra laissez-faire economics that if left unhindered to find its own balance would result in 'an Eden of plentiful employment, boundless creativity and zero inflation' (Klein 2007, p.50). Their success was visible in the influence of the policies of president Carter in the US and prime minister Wilson in the UK:

> 'These US based neoliberals formed the intellectual nodes at the heart of a transatlantic network of think tanks, businessmen, journalists, and politicians who spread an increasingly honed political message of the superiority of free markets' (Stedman Jones 2012, p.5).

The Chicago School doctrine as described in the words of Milton Friedman best describes the scope of their beliefs:

> ' In discussion of economic policy, Chicago stands for belief in the efficacy of the free market as a means of organizing resources, for scepticism about government intervention into economic affairs, and for emphasis on the quality of money as a key factor in producing inflation. In discussions of economic science, "Chicago" stands for an approach that takes seriously the use of economic theory as a tool for analysing a startlingly wide range of concrete problems, rather than as an abstract mathematical structure of great beauty but little power; for an approach that insists on empirical testing of theoretical generalizations and rejects alike facts without theory and theory without facts' (Friedman, cited in Valdes 1995 p.65).

This definition of their beliefs powerfully demonstrates both their conviction in the theoretical and evidence base of their School, but also the ideological conviction that accompanies their corroborations.

With the power of such deeply held convictions, they extended their net wider as they sought to export and indeed test their ideology through macroeconomic policies imposed on strategically chosen countries over whom they could establish influence, starting with Chile. Following a rejected proposal from the University of Chicago to Universidad de Chile, The Chicago School ideologues instead signed an agreement with The Universidad Catolica de Chile that would see them 'modernise' the teaching of economics in what was until then a School of Commerce, and provide opportunities for graduates to come to study under Friedman and his colleagues in Chicago. The economic philosophies of Chile were thereby directly influenced by the returning economists, "The Chicago Boys", who had studied under the guidance of Friedman and others in the Chicago School of Economics. Their activities and their research enabled the Chicago School to effectively use Chile as a "laboratory" to test their free market theories, a research agenda that was provided an opportunity by the 1973 military coup in Chile, and was then extended to other South American countries such as Argentina and Uruguay.

A moral justification for libertarianism

A seminal text published in the early 1970s served to seal the convictions of libertarians by making a compelling argument for free-market libertarianism. Robert Nozick's Anarchy, State and Utopia (ASU) (1974) responds to and forms a counterpoint to Rawls' A Theory of Justice and makes an argument for an ultra minimal state wherein he 'affirms the state-of-nature right of individuals to protect and enforce the first-order rights to life, liberty and property' (Mack 2011, p.90). In so doing, Nozick reignited an interest in the concept of rights that had become neglected in the field of political philosophy by his predecessors and his contemporaries and, more significantly for the purposes of this chapter, his book provided a compelling philosophical defence of free market libertarianism's moral basis:

> 'Deontological libertarianism, pioneered by Robert Nozick, is based on a strict doctrine of natural rights, violation of which is never permitted, whatever the consequences. The justification for such a

> theory is claimed to be a particular rights-based theory of justice (Wolff 2006, p.1605).

The significance of this text is said to have 'effectively moved libertarianism from a relatively unimportant subset of political philosophy to the centre of the discipline' (Bader & Meadowcroft 2011, p.1). Divided into three parts, ASU focuses on 'the nature of the state, its legitimate functions, and its justifications if any' (Nozick 1974 p.ix). Nozick first examines state-of-nature theory and argues that a minimal state is morally legitimate, before going on to argue against a redistributive state in the second part of the text, stating that a more extensive state could not be morally justified as it would violate rights. This minimal state provides a framework for the final section of his thesis, entitled Utopia, in which Nozick argues that:

> 'This morally favored state, the only morally legitimate state, the only morally tolerable one, we now see is the one that best realizes the utopian aspirations of untold dreamers and visionaries' (Nozick 1974, p.333).

The implications of his conclusions in favour of a morally justified minimal state are, he argues:

> 'that the state may not use its coercive apparatus for the purpose of getting some citizens to aid others, or in order to prohibit activities to people for their own good or protection' (Nozick, 1979, p.ix)

Nozick wrote this text between 1971 and 1972 at a time of much political and social strife in the United States, when anti Vietnam war protests continued to grow and public burning of draft cards demonstrated the public opposition to military conscription, yet at the same time prompted legislators to make such demonstrations illegal. His thesis offered an alternative view of a utopian society which he described as 'the best for all of us; the best world imaginable for each of us' (p.298). In disregarding the necessity and indeed the validity of the state Nozick put forward an argument that appealed to those on the right, who sought a moral and philosophical

support structure for their laissez-faire calculations, while simultaneously being disarmingly attractive to the anti-establishment protestors of the left. Nozick's contribution was seen as having transformed the libertarian case into a common sense one that no longer required defending. Anyone arguing against his thesis engaged in discourse that threatened violence to the dignity of the individual. Nozick's contribution was thus invaluable to the growth of neoliberalism into what Bourdieu refers to as the 'logical machine' of the 'pure and perfect order' of the economic world (Bourdieu 1998). While his arguments have not been without critics (Nagel 1975; Rothbard 1977; Kukathas 2011) his role in providing this thesis of a rights-based defence of an ultra-minimalist state, remains as a necessary philosophical underpinning for liberalism on its evolution towards neoliberalism.

It is important to examine ideologies like classical liberalism, and their evolving variants such as neoliberalism, in the context and history from which they have emerged. Turner puts this well when she says:

> 'Liberalism as a complex and pluralistic political ideology [..] has to be unpacked and clarified from within; it has to be understood as a number of internal variants in the form of traditions or phases. These traditions are composed of competing beliefs and practices, which form a part of the larger narrative that is history' (Turner 2008, p.22).

By examining the narratives of this history it can be seen that classical liberalism held a number of core tenets which were adapted into the stated objectives of the MPS and subsequently into what would be come the dominant neoliberal ideology, namely; the centrality of the individual and their freedom, the importance of free trade as a natural system of liberty, with minimal state intervention in the market, and the belief in spontaneous social order that would be created by an unfettered market. Through these principles, the classical liberals and their successors reasoned, human progress and flourishing, the ultimate goal of life in this world, would be best achieved. A closer examination of the manner in which classical liberal ideas have come to be manipulated and distorted, resulting in an alternative ideology, is

necessary at this point and will help in tracing the genealogy of current neoliberal ideologies.

The distortion of liberalism into neoliberalism

It can be seen from the preceding discussion that neoliberalism has its roots in the classical liberal tradition, with the term being first used in 1930s Germany. The term was used to:

> '…indicate the distinction between the prevailing pro-collectivist liberal ethos and the principles of traditional liberalism. Neo-liberalism established itself as a variant of liberal ideology, driven by the constellation of threats it faced from rival political creeds to the realisation of its liberal project' (Turner, 2008, p.4).

It is the amalgamation of the 'converging historical determinants' (Dumenil & Levy 2011) of neoliberalism that make the identification of a precise starting point of neoliberalism difficult. Furthermore, there is much difficulty in discussing neoliberalism and its evolution particularly because a universally accepted definition is elusive and there would appear to be numerous understandings of the term. Unlike other core concepts, few attempts have been made in economic, philosophical and social scientific literature to engage in sustained scholarly debate in order to reach a consensus on an understanding of its meaning (Boas & Gans-Morse 2009). Adding to this difficulty is the fact that use of the term neoliberal appears to have taken on a different, pejorative, and indeed in some cases, an opposite meaning from that intended by earlier writers. Stedman-Jones (2012) alludes to this difficulty with the term 'neoliberalism' when he says:

> 'The term has become divorced from its complicated and varied origins. It is too often used as a catch-all shorthand for the horrors associated with globalisation and recurring financial crises' (p.2).

In an attempt to map the changing use of the term neoliberalism in social science literature, Boas & Gans-Morse (2009) undertook a review of 148 published papers that had used the term. They identified three particular difficulties that surround the use of the word; '…the term is often undefined; it is employed unevenly across ideological divides; and it is used to characterize an excessively broad variety of phenomena' (p.137). Their analysis demonstrated a dramatic change in the use of the term between the 1960s and the 1980s:

> '…the shift from a positive term implying moderation to a negative term connoting radicalism resulted from neoliberalism's association with the economic reforms in Augusto Pinochet's Chile and other countries of the Southern Cone in the 1970s' (p.150).

The difficulties and ambiguities related to the term neoliberalism continue to cause confusion and misinterpretations in public discourse as well as in academic literature. In a speech by the President of Ireland, Dr Michael D. Higgins entitled 'Towards an Ethical Economy', he recalls the origins of neoliberalism in classical liberalism stating 'Neo-liberalism has operated a profound deconstruction of the special status classical liberalism conferred on human labour' (Higgins 2013a). He goes on to challenge the suggestion that neoliberalism lacked a coherent doctrine reminding listeners that:

> 'Neoliberalism has, from the first meetings of Ludwig Von Mises, Hayek and Milton Friedman, been a conscious ideological project. By looking at how certain structures of ideas came to prevail we can trace the origin of the contemporary suggested inevitability in policy prescriptions'.

While this speech was an interesting one and one that demonstrated the President's obvious depth of understanding of a wide range of literatures, what happened subsequent to this speech is telling of the ambiguity surrounding the term 'neoliberal'. Just over a week later the Economics Editor of the Irish Times, Dan O'Brien wrote a piece on this speech entitled: 'Ireland ill-served as President

becomes increasingly partisan and political' and more pointedly subtitled: 'Higgins has resorted to tiresome name-calling of the reactionary left, including their favourite term of abuse "neoliberal"' (O'Brien 2013, p.1). O'Brien goes on to criticise the President for the largely 'left' sources of literature that he cited and then confirms his belief that the term 'neoliberal' is a pejorative term used in name-calling, referring to it as:

> '…a label slapped on those whose views on the relative roles of market and state differ from theirs. Because nobody anywhere defines himself/herself as "neoliberal", this makes dialogue impossible and the making of conspiracy myths all too easy, as the President illustrated well in his speech' (p2).

As an economics editor with considerable experience in international economic affairs, O'Brien demonstrates a number of surprising misconceptions. Primarily of interest is his assumption that use of the term 'neoliberal' is, as he says in his subtitle, 'name-calling'. He demonstrates a reluctance to acknowledge that neoliberalism is a specific ideology with its roots in the classical liberal tradition. His second error is to confuse and conflate deeply held ideological positing with Politics and he criticises the President for using his position 'as a platform to advance a political agenda', stating that his 'interventions have become increasingly political and partisan'. However, this response to his speech demonstrated primarily a mainstream economist's position, in the country's paper of record, that regarded the term neoliberal as a pejorative one, thereby neglecting to acknowledge the genealogy of neoliberalism originating in classical liberalism. One point O'Brien makes is correct though; no-one identifies themselves as neoliberal. This is an observation also made by Boas and Gans-Morse (2009) in their analysis of the use of the term in the literature, noting 'virtually no one self-identifies as a neoliberal' (p.140).

Three letter writers the next day responded by commending the President, with one writer from the Max Planck Institute for the Study of Societies in Cologne pointing out the innocuousness of the term 'neoliberal' saying:

> 'The term "neoliberal" is increasingly used in political science to describe the paradigm shift away from demand-managed macroeconomics, during the Keynesian era, to the supply-side oriented revolution in economics during the period of financial market expansion' (Regan 2013).

Another letter writer commended the president stating that he had managed to:

> '…cut through the fog of ideological obfuscation to situate our present crisis in a longer-term historical trajectory and to remind us of what should be the objective of all economic activity, namely human flourishing'(Kirby 2013).

Kirby, an Irish academic in Politics and Public Administration, goes on to remark:

> 'Far from being ideological, the term "neo-liberal" has been extensively scientifically analysed to distinguish it from classical economic liberalism. That those who espouse these approaches to organising the economy don't accept this term is entirely beside the point'.

The final letter writer jokingly feigns horror at the President keeping the intellectual company of Foucault, Habermas and Lynch.

This contemporary exchange of commentary serves as a very useful indicator of the mixed conceptions of neoliberalism among academics, economists and politicians. The conflicting opinions of O'Brien and others on the use of the term neoliberalism is about much more than semantics. The issue at stake here is to do with the sheer dominance of an assumed ideology. It is about, as Massey puts it, 'the way that neoliberalism has become part of our common-sense understanding of life. The vocabulary we use to talk about the economy is in fact a political construction' (2013a). By definition, one of the hegemonic effects of commonly held assumptions and ideologies is that there is an inability to question or critique. As Peck (2010) puts it, 'It might be said about dominant policy paradigms like neoliberalism that it can be

difficult to think about them when it has become so commonplace to think with them' (p.i). Bourdieu (1998) contributes to our understanding of this normalising process when he says:

> 'Everywhere we hear it said, all day long - and this is what gives the dominant discourse its strength, - that there is nothing to put forward in opposition to the neoliberal view, that it has succeeded in presenting itself as self evident, that there is no alternative' (p.29).

When there is no alternative to the regime to which the citizen is subjected, the only strategy to adopt is one of self-inveiglement in order to be convinced that the regime is in fact preference. The measure of success of a hegemonic ideology is when it succeeds in developing to the point of appearing widely accepted, apparently innocent and even widely admired (Baggini & Fosl 2011) but at this point it can correctly be regarded as a device 'for control, manipulation and oppression' (Baggini & Fosl 2011, p.233). It can be argued then, that it is through this mechanism that neoliberalism has mutated from the classical liberal notions of freedom and autonomy to an instrument for the exercising of power. Massey refers to the manner in which the very vocabulary which is used in discourses of choice, freedom, responsibility, consumption etc. serve to shape out conceptions of relationship with the world and, furthermore, she argues that:

> 'These "descriptions" of roles, exchanges and relationships in terms of a presumption that individual choice and self interest does and should prevail are in fact not simply descriptions but a powerful means by which new subjectivities are constructed and enforced' (Massey 2013b, p.5).

The reluctance of writers and thinkers in the economic and philosophical fields to openly identify themselves as neoliberal is an interesting phenomenon and one that is worthy of further analysis. In some respects it could be regarded as a case whereby those ascribing to neoliberal ideology have begun to 'believe their own publicity' or in this case their own critics, and they are uncomfortable with this. While the origins of neoliberalism have been traced to the classical liberal tradition, the

contemporary formulations of neoliberalism have become very far removed from many of the core tenets of the classical ideology. For example, Smith emphasised the centrality of the individual, but a free individual who remained part of a society. The neoliberal incarnation or distortion of this concept has withdrawn the individual away from society resulting in Margaret Thatcher commenting that, 'There is no such thing as society'. Personal responsibility and individualism have replaced Smith's conception of the free individual. 'The more we imagine that we are disconnected from each other, the easier it is to turn us into market targets' (Allen 2011, p.51). In an atomised individualised society where each is free to further their well being to achieve flourishing, there is a blinkered view of obligations as entirely self—serving. Gerber argues that this is not what was intended by the original writers on liberalism: 'Lockean liberalism's commitment to an individual's natural right to take full advantage of his unique abilities and capacities so as to enjoy the fruits of his natural freedom does not mean, however, that an individual is never required to share his wealth' (Gerber 1996, p.51).

The freedom that Mill and Smith spoke of was of a more egalitarian hue than that which is propagated by contemporary neoliberalism. Freedom has been distorted to mean instead a range of choice within the market. Prozorov (2007) refers to such abuse and devaluation of the notion of freedom citing the urban truth of the 'freedom fries' and the overuse of the word in the justification of American military campaigns saying that '..it becomes increasingly difficult to speak about freedom outside the context of its use as an instrument of authority' (Prozorov 2007, p.2).

A further example of distortion of original tenets of classical liberalism is seen in examining the role of the state and the removal of restraints. Here free trade was said to create a natural state of liberty. Again, returning to the fathers of liberalism their intention was that such free trade would be to the benefit of all and that it would enable the elimination of poverty. Instead the actions of the consumer in the marketplace becomes an expression of human freedom (Stedman Jones 2013). Friedman's interpretation of this principle is one that warns of the dangers of government involvement in voluntary exchanges:

> 'In the government sphere, as in the market, there seems to be an invisible hand, but it operates in precisely the opposite direction from Adam Smith's: an individual who intends only to serve the public interest by fostering government intervention is "led by an invisible hand to promote" private interests, "which was no part of his intention"' (Friedman & Friedman 1980, p.6).

His fear, it appears, is that individuals of which governments are made up and others of power, will influence government for personal gain. This probability appears paradoxical to his location of the free individual as central to his thesis; one which relies so crucially on the actions of the rational self interested actor in the competitive market place. Contemporary neoliberal ideology emphasises the individual in a central role in all market activities that are unfettered and free from all state influences.

So it can be seen that the residual institution of classical liberalism retains some place in the realm of contemporary neoliberalism, but it no longer holds its original form. It has been influenced by history and contemporary developments within the evolution of capitalism. Dumenil and Levy (2011) identify neoliberalism as one of a number of stages in modern capitalism

> 'modern capitalism, meaning capitalism after the corporate, financial, and managerial revolutions, that is, from the turn of the twentieth century to the present, and neoliberalism is described as the third and most recent phase of modern capitalism' (2011, p.10).

Capitalism continues meanwhile to be legitimised and unquestioned as are the ideas and beliefs that underpin it. Ingham (2008) examines the role of the state in legitimising capitalist social relations and suggests that there are a number of reasons for 'the apparent general acceptance of the inequality and exploitation that capitalism inevitably produces' (p.183). He goes on to explain:

> '…there is much to be said for this argument that capitalism and its inequalities are not accorded positive legitimacy, but merely accepted in the absence of both alternative visions and the power to make changes' (p.183)

The repeated discourse that "there is no alternative" certainly contributes to this acceptance as does the erosion of a collective conception that might invoke the power to make changes.

The financial crisis that emerged from 2007/8 onwards has prompted some to suggest neoliberalism as an economic approach in capitalist economies has failed and is without a future. While governments may have briefly flirted with the notion of returning to Keynesian economic policies in the wake of the crisis, all have returned to Hayekian and Freidmanian strategies and severe austerity measures. As a combination of neoclassical economics, monetarism and supply-side economics, neoliberalism constitutes a powerful and compelling approach. This crisis has undoubtedly coloured conceptions and has perhaps shaken the beliefs of many in the neoliberal church, to the extent that future iterations of free market ideologies may have to be shaped differently:

> 'As we see it, capitalism in its relatively short but advanced neoliberal phase has set the stage for a momentous but as yet indeterminate struggle to organise and mobilise the forces of change in possibly a capitalist or socialist direction' (Petras & Veltmeyer 2013, p.3)

Neoliberalism in its current form has become a negatively driven programme, that is to say, it is easier to say what it does not agree with than it is to identify with precisely what its objective is. It could be said to no longer be engaged in real agenda setting. However, even if it is not enjoying the wide scale evangelising activities of the 1970s, neoliberalism remains the dominant ideology in Western economies and future economic policies will forever be stamped with their origins in classical liberalism. Its history is relatively clear, but its future is less so. In the circumstances it is reasonable to suggest that with 'the demise of neoliberalism as a

mobilising ideology and economic doctrine - the outcome is uncertain' (Petras & Veltmeyer 2013, p.5).

Neoliberalism in Ireland

Neoliberalism, with its origins in classical liberal ideology as discussed earlier, can be simply defined as a particular political and economic philosophy that favours the dominance of market forces on the core organising principles of society. For the purpose of this chapter it is useful to explore the impact of neoliberalism on a number of levels; that of the economic and social policies (health and welfare), that of society and consequently on the level of the individual. Coburn (2000) refers to the neoliberal philosophy as having three core tenets:

> '1. that markets are the best and most efficient allocators of resources in production and distribution; 2. that societies are composed of autonomous individuals (producers and consumers) motivated chiefly or entirely by material or economic considerations and 3. that competition is the major market vehicle for innovations' (p.138).

An application of these tenets to health care can be seen to have emerged strongly in many health services with the most extreme being that of the US model. However, other health care systems can be seen to also be subject to influences of market forces with the autonomous consumer subjected to the influence of market competition.

As discussed earlier, the drive of the neoliberal agenda has, since the early eighties with the ideologies of Thatcher and Reagan, been heralded as the one true economic approach. Through this school of thought there is minimal state intervention with a central role for the market to influence local, national and international political decision making and thus, it can be argued, societal perceptions of normative values are influenced. Author of the seminal and accessible text on neoliberalism, David Harvey defines neoliberalism thus:

> 'Neoliberalism is in the first instance a theory of political economy practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets, and free trade' (Harvey 2007, p.2).

The recursive relationship between economic ideas and philosophical ideas is modelled by neoliberalism and consequently while ideas evolve so too do the principles and policies that are implemented. While the origins of these ideas can be traced back to classical liberalism, a particularly strong shift in policies in the UK and the US is often described as having begun in the late 1970s and resulted in near global neoliberalism by the 1980s. The influence on Ireland can be seen to have been a later and perhaps a peculiarly idiomatic one, but it was nonetheless an influence that supported reduced state involvement in many aspects of social life. Having witnessed the wholesale adoption of neoliberal economic policy in neighbouring political economies in the 1980s and waves of privatisation of state services, successive Irish governments implemented a regional variation of neoliberalism. The peculiarities of the version of neoliberalism evident in Ireland, the mechanisms of which will be discussed later in this chapter, include a demonstrable shift from an already conservative model to a wholesale market model.

Kitchin et al (2012) identify four particular historical factors that have shaped Ireland's neoliberal model. They specify Ireland's long history of conflicts over land ownership, the residual institution of clientelism in politics that favours local politics over national, the hegemony of two right-of-centre political parties that do not differ on clear ideological grounds and the tendency towards a liberal open economy with an over-reliance on export-oriented manufacturing:

> 'These four factors shaping the Irish political landscape have produced a certain species of neoliberalism in Ireland which is perhaps best characterised as ideologically concealed, piecemeal, serendipitous, pragmatic, and commonsensical' (p.1306).

Contradicting the contention that Ireland's so-called hybrid model, placed somewhere between Berlin and Boston, was an intentional strategy, Kitchin et al. instead describe Ireland's 'peculiar brand of "emergent" neoliberalisation' (p. 1306) as '… a series of disparate policies, deals, and actions which were rationalised after the fact, rather than constituting a coherent plan per se' (p.1307). Not all would agree with Kitchin et al's assessment of an ad-hoc process of neoliberalisation. Mercille (2013), for example, states:

> 'Although Irish governments have never explicitly adopted a neoliberal ideology, political economic institutions have nevertheless been transformed along neoliberal lines. This 'neoliberalism Irish-style' has borrowed elements of US neoliberalism, such as public–private partnerships, privatisation of public services, low corporate and individual taxation, low level of government expenditures on social programmes and light regulation of the financial system' (Mercille 2013, p.2).

Perhaps ad-hoc is not so much the correct description of Irish neoliberal policy-making, so much as covert. Indeed, it could be argued that the process of describing neoliberal policy implementation as 'ad-hoc' succeeds in contributing to the ideology that suggests it is accidental or organic, reminiscent of Smith's concept of spontaneous order.

Far from accidental, some have suggested that pushing countries to the point of crisis enables the neoliberal ideologues an experimental opportunity to test the limits of citizens' tolerance. Sheehan (2013) describes the volatility of the neoliberal economic experiment on-going in the Greece that she describes as a 'crucible':

> 'Greece is at the sharp end of a radical and risky experiment in how far accumulation by dispossession can go, how much expropriation can be endured, how far the state can be subordinated to the market' (p.1).

Closer to home, in another country in crisis, the Tánaiste (Deputy Prime Minister) and leader of the Labour party in Ireland, Eamon Gilmore, suggested in September 2013 that the so called "Troika" of lenders - the European Commission, the International Monetary Fund and the European Central Bank, whom he referred to as 'austerity hawks', were using Ireland as 'some type of economic experiment' (Smyth 2013). Gilmore's concerns are not misplaced when one considers that neoliberalism has, in the US, a track record of utilising vulnerable countries near crisis as testing grounds, as was seen in Chile and other South American countries in the past.

However, whether neoliberal policy implementation has been ad-hoc, intentional or experimental, it was, and arguably remains, unquestioned and dominant. Critics have pointed out that the hegemony of neoliberalism and neoclassical economical thinking in Irish economics resulted in little critical examination of the approach and thus a failure to identify serious structural weaknesses that would later prove so critical.

As referred to earlier, a particular strength of the neoliberal ideology can be seen in the manner in which it is promulgated through discourse in mainstream media (Bourdieu 1998). Phelan (2007) provides an insightful analysis of 'the role of discursive practices in the hegemonic articulation of an Irish neoliberalism' (p.44), and in particular he identifies the key role that 'mediatized discourse' plays in the 'production and reproduction of an Irish neoliberal hegemony' (p.31). While distinguishing between what he calls 'Euphemised' and 'Transparent' discourses on neoliberalism, he demonstrates the equivalences and antitheses used to distinguish the comprising concepts of neoliberalism:

> 'The market is equivalenced as the sphere of economic freedom, while the state is signified as the embodiment of illusory, and ultimately coercive, political freedom. The notion of a self-contained individual subject is privileged, ontologically and epistemologically, while invocations of a collective subject (the 'social', the 'public good', etc.) are regarded with suspicion. The market is valorized as

> the means of individualized ends, while the misplaced […] politics of social purpose or collective ends is equivalenced with rationalistic, statist fallacies' (Phelan 2007, p.34).

It could be argued that a multidirectional process of influence might exist within which social policies ultimately become victim to the discourses emitted by the craftsmen of political spin, but more worryingly, also influenced along this process are consumers of partisan media. Their apparent acquiescence is interpreted from an already silenced citizenry who lack a collective voice.

The Private versus the Social

The notion of the collective is one that is frequently associated with a left wing, social democratic persuasion (Turner 2008; Grady 2010). When the concept of the collective is pre-eminent, consideration is given to the common good instead of actors seeking to satisfy their own individual needs. The 'good life' is pursued for the society as a collective whole, eclipsing the objectives of the lone actor. Collectivism, therefore, demands a level of solidarity among and between people and assumes a genuine interest in the consequences for all sections of a society. When this concern is set alongside the concept of individualism, frequently championed by those of a more neoliberal conservative political persuasion, a stark difference can be seen. But this difference is only seen in the more contemporary iterations of liberalism as neoliberalism which bare little resemblance to the ideals of liberalism of a more classical description, as discussed earlier. For example, the two core tenets of liberalism are described by Nagel (1975) who states:

> 'Liberalism is the conjunction of two ideals. The first is that of individual liberty: liberty of thought, speech, religion, and political action; freedom from government interference with privacy, personal life, and the exercise of individual inclination. The second ideal is that of a democratic society controlled by its citizens and serving their needs, in which inequalities of political and economic power and social position are not excessive' (p.136).

Nagel points to the difficulties when he says: 'To approach either of these ideals is very difficult. To pursue both of them inevitably results in serious dilemmas'. It is the second of these ideals that is difficult to locate in current neoliberal ideology and its policy makers. A focus on collectively beneficial and egalitarian strategies has been eroded and in its place a strong sense of individualisation has evolved (Meulen & Jotterand 2008).

The tendency towards individual interests in place of those of the collective is not merely seen within the decision making of the individual actor, but is also seen in a broader sense within political economy and social decision making. Much of this can be understood within the context of the drive towards neoliberalism within capitalist countries, but also can be traced against other social, political and economic changes. In Ireland the shifting powers of the Catholic Church, for example, is a particularly significant social, cultural and moral change that has gained much critical attention and can also be mapped closely to this shift from the collective to the individual (Hardiman & Whelan 1998). This will be discussed further later in this chapter.

Irish interpretations of providing for health and welfare needs of its citizens can be seen to be deeply at odds with perceptions in other countries such as the UK, with the remnants of its enviable NHS, and health systems in many South American countries such as Cuba and Venezuela. In Venezuela the 'Barrio Adentro', for example has revolutionised the manner in which basic health needs are provided for people within their communities, with the concept of solidarity at its core and the ability to pay for such care nowhere to be seen (Brouwer 2011). The interpretation of health care seen in Ireland is not one that possesses qualities of co-operative system or one that demonstrates features of reciprocity. Instead notions of deservedness and self determined outcomes abound. Health and welfare needs are seen as areas for which the private individual must concern themselves through their actions as consumers. It is useful at this point to examine this culture of the private individual within the context of the hegemonic economic influence of neoliberalism as it can be seen as a predominant technology of power to which citizens are subject. How this situation has come about, supported by the theses of Friedman, Hayek and Nozick, is the subject of this chapter and indeed much of this thesis.

Mechanics of neoliberalism

The mechanisms of neoliberalism are demonstrated very effectively in several areas of Irish public policy, as well as within the realm of Irish health and welfare policies, where the strategy of New Public Management, privatisation and outsourcing of services are the commonly used apparatuses of neoliberal ideology. While transferring market oriented policies of the private sector into public sector realms (Hood 1995), policy makers have, since the 1980s sought to improve efficiencies across the public areas of health, education, housing, defence and the criminal justice system. New public management (NPM) is characterised by 'calls for strengthening the play of market forces in public services and a reduction of state interventions' and is 'characterised by delegation, decentralization and devolution' (MacCarthaigh 2012, p.25). While Ireland was something of a late starter in terms of adoption of NPM policies, it has been seen to have utilised NPM in an ad-hoc manner and with a strategy that lacked coherence (MacCarthaigh 2012).

The Education sector in Ireland, for example, has seen a significant increase in the growth of the private for-profit colleges and schools, particularly in more affluent urban areas. In this example, students and parents are encouraged to turn to the market to seek private education to supplement that which is provided by the state. In this market the end product of successful graduation, points and grades are the measurable outcomes that are scrutinised in order to assess successful competition. Teacher education in Ireland has also become subject to the market in Ireland as the government welcomes private providers like Hibernia College to provide private teacher education with no cost to the exchequer. Lynch (2006) warns 'There is an increasing attempt to privatise public services, including education, so that citizens will have to buy them at market value rather than have them provided by the State' (p.1). In the universities too NPM managerialist policies are changing the traditional more collegiate way of life for many academics and researchers.

A further example of neoliberal policy influence can be seen within the domain of the housing in Ireland, and particularly in the area of social housing, where the dominance of private property remains an organising principle of Irish housing

policies. Here the private rented sector is strong and the landlord remains in a position of power and authority, by virtue of his ownership of property, or as Nozick (1974) refers to it, an 'initial acquisition', they are able to dictate the living conditions of the tenants who remain at the mercy of the market. Those tenants who are lucky enough to be in receipt of rent-allowance, a supplement provided by the state's social welfare system, may be refused and excluded by the landlord. This discretion effectively forces poorer families and individuals to compete for a smaller and more limited housing pool. Again, the market is hegemonic as the vulnerable actor is subject to its fluctuations and vagaries. The presence of commercial interests in a realm more correctly located as a responsibility of a democratic decommodified welfare state, serves to oppress those in need of the basic human requirement of shelter. The sheer imbalance of power distorts what neoliberals describe as a kind of inherent justice in the market. Pension provision provides a further example of the role of market where a welfare state should be. Increasingly, the responsibility for the citizen's pension and thereby their protection and security in old age is that of the individual as an engaged player in a market, and less that of the state. Those in a position to purchase such security are encouraged to do so via tax relief on their pension contributions.

Health care, as a core tenet of any welfare state, is in many ways not very different from education, housing or pensions and it serves as a very useful case study through which an examination of social consequences of social and economic policies can be performed. However, the life and death features within the domain of health care make the consequences more stark. Despite the centrality of health care provision to any democratic welfare state, providers seek to undermine this standard by instead locating health care, not as a right or entitlement of citizenship, but within the marketplace, a site where entitlement comes only with purchase power. Consequently, the citizen in Ireland is consistently subjected to a barrage of messages that inform them of a sense of deservedness to a better, swifter and more effective form of health care. However, in order to achieve this they must choose to engage in the market and to elevate their status to that of a 'private patient'. In so doing they remove themselves from the communal world of the 'public patient' and from the world of waiting lists, public wards, delayed treatments and, as the evidence shows, poorer health outcomes (Tussing & Wren 2006).

These examples of a dominating culture of privatisation and individualisation in a number of social policy contexts succeed in contributing to a changed sense of social expectations and norms among public perceptions. Navarro (2007), describing neoliberalism as 'the ideology and practice of the dominant classes' (p.53), states simply that the promotion of individualism and consumerism by the neoliberal agenda results in 'hurting the culture of solidarity' (p.53). It is with precisely this impact on collective notions such as solidarity that this thesis is concerned. Instead of being the concern of the collective nation, the health and welfare of the citizen is a private marketable concern. Bourdieu is similarly concerned about the impact of neoliberal policies on the collective describing how neoliberal 'methods of rational control which […] combine to weaken or destroy collective references and solidarity' (Bourdieu 1998, p.98)

It can be seen, therefore, that neoliberalism eliminates state intervention in areas such as health, welfare, and education and places the responsibility back squarely with the individual to meet these needs through their own resources. Harvey (2007) warns of the consequences of this move:

> 'As the state withdraws from welfare provision and diminishes its role in arenas such as health care, public education, and social services, which were once so fundamental to embedded liberalism, it leaves larger and larger segments of the population exposed to impoverishment' (p.76).

The individual actor within the neoliberal state finds themselves in a condition of vulnerability to the burdens and risks of life, the impact of which will be inversely related to their ability to purchase protections for themselves and their family. It is from just these vulnerabilities that the welfare state is expected to protect its citizens through the maintenance of a social contract. Any country's welfare state serves as an indicator of the values that are highly regarded in that society; values such as equity and solidarity (Prainsack & Buyx 2011). The concept of solidarity has in the past been a strong ideological driver in the establishment of many health and welfare

systems throughout Europe. Prainsack & Buyx (2011) caution that the value of solidarity in Europe is under threat, citing Ter Meulen et al. as saying, (2010) 'The welfare state and its solidaristic arrangements of health and social care have already been under strain'(p.xv). Ter Meulen et al. go on to warn that:

> 'There is increasing uncertainty about whether solidarity still is or can be a guiding principle in the shaping of care arrangements within welfare states in the decades to come' (p.1-2).

So it can be seen from this discussion that the hegemony of neoliberalism is perpetuated through the sheer strength and breadth of the activities of policy makers, of think tanks, of publications that counter notions of collectivism, coupled with a disarmingly persuasive appeal to each individual's concerns for themselves. Such economic and disciplinary ideology in the form of neoliberalism has succeeded in eroding the significance and strength of conceptions of the collective and solidarity, and thus the strength of the welfare state in Ireland among other nations. To consider this process specifically in the context of Ireland's health care system it is important to return briefly to the issue of accurately describing Ireland's welfare state and its particular features.

Established Hegemony

Having established the scope of neoliberal ideology in the political, economic and social life in Ireland, it is now worthwhile to examine how it has come to dominate at the level of the individual. How is it that the preponderance for a particular economic system has come to promote individualisation in many aspects of our social world? Bourdieu describes the discourse that has contributed to such hegemony:

> 'For neo-liberal discourse is not a discourse like others. […] It is a "strong discourse" which is so strong and so hard to fight because it has behind it all the powers of a world of power relations which it helps to make as it is, in particular by orienting the economic choices of those who dominate economic relations and so adding its own - specifically symbolic - force to those power relations'(Bourdieu 1998, p.95)

Such 'symbolic inculcation', Bourdieu says, involves journalists as well as ordinary citizens who are subjected to 'a symbolic drip-feed to which the press and television news contribute very strongly' until 'as a result, neo-liberalism comes to be seen as an inevitability' (p.30). Harvey (2007) similarly attempts to explain this process, as would apply to any dominant ideology, when he says:

> 'For any way of thought to become dominant, a conceptual apparatus has to be advanced that appeals to our intuitions and instincts, to our values and our desires, as well as to the possibilities inherent in the social world we inhabit. If successful, this conceptual apparatus becomes so embedded in common sense as to be taken for granted and not open to question' (p.5).

What desires and instincts does neoliberalism offer us that enables its large scale adoption as common sense? The most evident appeal is that of its relationship to the very human instinct of self-preservation and its promise of security. This is achieved because vulnerabilities and weaknesses are exploited through exaggeration of risks. A solution and a means to avoid such risk is offered within the market, with the

reminder that: 'you're worth it'. Such engagement in the market to pursue protection, by its very nature, is exclusionary. The consumer sets themselves aside from others and the process of individualisation and atomisation has begun. As Powell & Guerin (1997) state; 'The moral individualism of Thatcherism and Reaganomics quickly mutated into hedonistic individualism' (p.20). The roots of this individualism can be clearly traced back to the core principles, though mutated, of classical liberalism as were discussed earlier, including the primacy of freedom and the minimised involvement of the state.

In the neoliberal market society the individual who seeks their own means to protect themselves and their family are cast within the attributes of having 'taken responsibility'. Those who are unable to do so, conversely, are depicted as irresponsible dependents, leeching off the state and its taxpayers. Through this mechanism society is cleanly divided between the deserving and the undeserving and thus a disciplinary residual welfare state emerges. The realm and scope of the social world becomes increasingly limited and the ability and obligation of the state to provide social needs, such as a health or welfare state is seen more and more cynically by its citizens (Giroux 2011):

> 'As the realm of the social disappears, public values and any consideration of the common good are erased from politics, while the social state and responsible modes of governing are replaced by a punishing state and a Darwinian notion of social relations' (Giroux 2003, p.195).

In another publication Giroux points to the self perpetuating nature of neoliberalism when he says, 'Neoliberalism not only dissolves the bonds of sociality and reciprocity; it also undermines the nature of social obligations by defining civil society exclusively through an appeal to market-driven values' (Giroux 2005). Without these bonds to hold the social world in some fashion of a community, there is little opportunity to organise and mount a reasonably critical strategy for an egalitarian alternative. Shaoul (2001) similarly warns that the very dominance of neoliberalism explains '…why the traditional organisations of the working class and intellectuals

have been unable to mount any effective opposition or critique of the neo-liberal agenda' (p.213).

A further mechanism by which individualisation appeals is the manner in which it claims to invoke 'choice' and by implication therefore a sense of freedom; a freedom of choice. Such a feature appeals to our instincts of self determination and makes promises of future possibilities when investments are realised. This freedom to choose is a far cry from the freedom and liberty of each man with which Adam Smith was concerned. The classical tradition has been distorted to the point that 'you get to choose' is synonymous with freedom and is positioned as preferable to 'the state will provide for you', while the 'freedom to choose' has replaced true liberty, rights or entitlements.

Furthermore, when the citizen engages with the market to meet their needs in an individualised manner they establish themselves as 'within' a group, such as, the insured, the private patients, the private tenant, the clients. By virtue of this, others are by necessity excluded. Those within are deemed protected club members, the 'other' is outside this elite group and remains vulnerable and excluded.

Club theory

Social exclusion and social fragmentation has been explicated and extensively theorised as 'club theory' by Jordan (1996) who argues that, '…the welfare of vulnerable individuals…depends upon their rights as members of social collectivities' (p.42). Club theory is particularly useful in this analysis of the individualisation of Irish social life as it:

> '…shows how individuals with different capabilities, resources, risks and vulnerabilities interact in relation to group formation and exclusion, and explains the circumstances in which the most vulnerable will be included in collective goods, as well as those in which they will be excluded' (Jordan 1996, p.62).

Modern Irish society portrays numerous examples of social dissection that can be interpreted as the formation of informal clubs. Aside from formal elitist and exclusionary clubs such as golf clubs, GAA clubs and the like, informal arrangements such as gated communities and residents' associations also abound. Religious groups, Irish language groups and private schools with stringent entrance requirements also succeed in excluding many. However, even more subtle formulations of exclusion have evolved that serve to retain public goods out of reach of many, and thereby succeed in exploiting and dominating. Referencing Bourdieu et al (1999), Forbes and Wainright (2001) refer to formal groups and clubs as:

> '…instruments through which social inequalities are perpetuated, and the higher incidence of group membership in affluent communities could equally be explained by the desire of those communities to define themselves as being separate from those deemed to be of lower status, thereby maintaining their position in the social order' (Forbes & Wainwright 2001, p.803).

By definition clubs are exclusionary and serve to divide the wider societal collective in favour of that of the smaller cooperative within. Those excluded tend to be those who are most vulnerable. Jordan helps us to connect this effect to market forces saying:

> 'Vulnerable people are vulnerable precisely because they are in no position to organise under market conditions. Markets provoke collusions that block the potential benefits of competition to the poor' (Jordan 1996, p.77).

Irish health care provides many very illustrative example of these exclusionary processes in action. The most evident of these examples is the creation of the 'private' health care club. Here paid up members who have fully internalised the concepts of privilege and entitlement literally buy themselves better care, swifter care and more technologically advanced diagnoses. Privileged members, by virtue of their economic status are spared the indignities of waiting lists, queues and, crucially, are

sheltered from experiencing the public sphere that is a public hospital bed space. The growth of the private health care sector infringes directly on the space of public health care, both metaphorically and literally. Co-location of private hospitals on the grounds of public health facilities has enabled the leeching of patients into the private sector, the use of publicly provided diagnostic and ancillary services as well as making the transition from one role to another extremely convenient for the consultant who practices in both the public and the private sectors.

The shrinking public spaces that serves to exclude many from the public sphere in Ireland are illustrated by Lynch (2010):

> 'the lack of commitment to the good of the public sphere is evident when public and private interests collide; it is evident in the way space is organised and the quality of the built environment between public and private hospitals, in the relative luxury and comfort of private rooms versus public wards; it is visible in the pitches, tennis courts and other facilities in well-off schools compared with the bare yards of small fields that are there for those in less-well-off or poorer areas' (Lynch 2010)

Giroux (2005) draws on similar examples in the US:

> 'As neoliberal policies dominate politics and social life, the breathless rhetoric of the global victory of free-market rationality is invoked to cut public expenditures and undermine those non-commodified public spheres that serve as the repository for critical education, public dialogue, and collective intervention. Public services such as health care, child care, public assistance, education, and transportation are now subject to the rules of the market. Social relations between parents and children, doctors and patients, teachers and students are reduced to that of supplier and customer, just as the laws of market replace those non-commodified values capable of defending vital public goods and spheres'.

Functional to the growth of this marketised world with a shrinking public sphere and increasingly important role for the market, is the narrative and practice of privatisation. Collyer and White (2011) refer to this process as a new social phenomenon that has 'become wedded to a world view focused closely on limiting the role of the nation state' (p.239). Exploring the impact of privatisation on health care and the global marketisation of health care systems, they define privatisation as one where the boundaries between the private and public sectors are re-arranged. This, they suggest, has the effect of smoothing 'the entry of new (private sector) players into the public sphere' (p.239). Privatisation can be seen to also contribute to the socially exclusionary practices that Jordan refers to in relation to clubs, as it succeeds in taking public spaces as well as public funds and moves them out of reach and instead places them in the hands of the private providers. Extolled as a legitimate strategic move that will deliver efficiencies, Collyer and White warn that privatisation in health care constitutes:

> '…A threat to the large public institutions providing services and protecting the rights of the under-privileged; undermining the capacity of the nation state to continue to plan, monitor and regulate the health needs of the population; cutting the hard-won working conditions of health and medical workers; and removing the access of patients to free or subsidised, high quality healthcare services' (p.238).

Such significant developments and shifts in economic and social policy, as well as the consequent changes in social attitudes to health and welfare provisions, are subject to numerous influences. In Ireland the dominance of the Catholic church, as discussed in Chapter 2, has been very significant. However, while all of these examples are helpful in depicting the range of the phenomenon of individual segregation visible in the Irish social world, again they do not explain why club formation has become necessary and instead they prompt us to seek to find suitable theory to do so.

The Influence of the Catholic Church

Ireland's history as a largely catholic country cannot be underestimated in this shift from public to individual. As a hugely significant hegemonic influence on Irish social lives, its role in shaping this situation must be examined. What role has the church played? Could it be argued, for example, that for decades Ireland's perceptions of the correct place of the collective was closely associated with the church or, to go further, at mass? Could it be speculated that actions of solidarity revolved around mass going, prayers and collection boxes? Further, could it be argued that religious dogma succeeded in limiting Irish consciousness surrounding issues of the collective to within the sphere of the church. Saunders (2012) suggests that solidarity usually entails a level of recognition restricted to others within the same interest group.

> 'Solidarity is usually understood to involve feelings of group identity or some common project, which is sometimes taken as a prerequisite for the demands of social justice to apply' (p. 377).

A strong group identity among Irish Catholics in the past is likely to have enabled solidarity extended only to those within the common project of the Catholic Church. The politics and ideologies of socialism and communism have never enjoyed significant popularity in Ireland. The Irish Catholic Church for many years portrayed communism as a sinister and nefarious concept and indeed exploited the consequent fear of communism to its own ends (McGarry 1999; O'Connor 2009). As discussed earlier in Chapter 1 of this thesis, the church strongly disputed the role of the state in providing for citizens' social or welfare needs, but at the same time, it was equally intolerant of a role for unfettered market forces. A Catholic 'third way' manifested itself in the form of their principle of subsidiarity.

The ideological control that the church's position was able to exercise in relation to the matters of state provision in health and welfare, demonstrates the power that the church held in Irish politics and consequently exerted on Irish social policy. As will be explored in Chapter 6, the church has vehemently opposed historical attempts to introduce health policies that were seen by the hierarchy as 'communistic' or

'socialist health care', despite the potential for significant health benefits for their flock.

Furthermore, Catholic social teaching and the associated philosophy of subsidiarity, certainly before the Second Vatican Council in the early 1960s, was strongly opposed to state involvement in issues of welfare with some in the church referring to 'Welfare totalitarianism' and to the welfare state as 'a variant of the cruder methods of Nazism, Fascism and Communism' (Fr Felim O'Briain, cited in Powell & Guerin 1997 p.37). The power and influence of the church in Ireland, whilst now significantly diminished, has left a residual placeholder which retains a space into which notions of solidarity, charity, altruism, gifting and similar notions of collective social obligations were formerly occupied by religious association.

The Individualised and Subjectivised citizen

A number of very significant forces can be seen to be at play in the social world of the Irish citizen. These forces of church, state, market forces, neoliberalism with its attendant individualisation and exclusion has, this thesis argues, resulted in repressive and disciplining subjectivisation. The citizen in Irish market oriented society and under a neoliberal regime, has become self-disciplining through internalising the individualising imperatives of neoliberal forces. This process of subjectivisation results in the creation of a particular type of subject whose genealogy is complex and extensive. The subjectivised citizen is cast primarily as a consumer and their 'worth' to society is measured entirely by their capacity to engage in the market society. This individualised ideal type corresponds to an atomised society that has been systematically divided. This division can be seen to have been endorsed through specific discourse utilised by the neoliberal agenda and in turn interpreted and rewritten by the citizen resulting in subjectivity (Fox 1997). Foucault identifies the process of subjectivisation as the citizen becomes subject to power through use of such discourse and an internalising of the power within the discourse, to which they are subjected. The precise source of this power is difficult to isolate. Indeed, some of the forces mentioned above have historically been difficult to distinguish from each other.

Having already examined the arguable role of the church in subjectivising the Irish citizen, it is worthwhile now to examine the potential force of the state. Foucault suggests that the modern state can be seen as:

> '…a very sophisticated structure, in which individuals can be integrated, under one condition: that this individuality would be shaped in a new form and submitted to a set of very specific patterns. In a way, we can see the state as a modern matrix of individualization or a new form of pastoral power' (Foucault 1982a p.214-215).

Springer (2010) also draws on Foucault's interpretation of subjectivation in his examination of 'a neoliberal discourse that systematically constructs subjects and the worlds of which they speak' (p.931), pointing out that he:

> 'emphasized processes of "subjectivation'', whereby individuals are made subjects through their everyday functioning as transistors (and resistors) in the circuits of knowledge via the "from below" productive power of governmentality, which imposes particular laws of "truth"'(p.931).

The related concept of the individual is raised when Foucault points to numerous 'struggles' that have developed in the modern world and identifies that they feature many commonalities:

> 'They are struggles which question the status of the individual: on the one hand, they assert the right to be different and they underline everything which makes individuals truly individual. On the other hand they attack everything which separates the individual, breaks his links with others, splits up community life, forces the individual back on himself and ties him to his identity in a constraining way' (p.211-2).

With particular relevance to this chapter, Foucault goes on to refer to the 'government of individualization' (p.212). Here we see the issue of government or state raised as a power-wielding entity.

The discourse of individualisation relies also on the concept of responsibility. A discourse of 'responsibilisation' can be seen to be active across the whole discipline of public health where individuals are expected to 'take responsibility' for their health, professionals are expected to 'empower' the patients and clients to do so and all of this with little regard for the immutable and hugely influential social circumstances which have undoubtedly contributed in some way to their condition. This discourse also permeates the field of public health in the area of health inequalities where official responses to disparities in health are frequently met with official responses that reference individual lifestyle choices. Stepping discretely into this series of discourses is the private health insurance market. Smooth ground has been prepared for its entry by the strong discourses of individualisation and responsibilisation, and the private health insurance providers will chime-in with the subsequent individualising of blame that subjectivisation facilitates.

Natércia (2006) suggests a similar process of subjectivisation as a consequence of neoliberal ideology saying:

> 'In the branch of neoliberalism which today creates visible effects of subjectivization, the whole being of the human is transformed in capital. Human capital, but capital nonetheless. Each one should work in the direction of increasing this capital, increasing the return in the form of income. One sees oneself repeatedly in the face of strategic choices in relation to investment' (Natercia 2006, p.2)

These strategic choices are presented to the consuming citizen through the use of media discourse identified by Phelan (2007) as being used in particular ways to promote the neoliberal ideology. This process could be more correctly described as the use of technologies of power in order to dominate and subjectivise.

Conclusion

This chapter has demonstrated the collusion of numerous sources of power and influence that have collaborated to enable the private individual as consumer to eclipse the community of citizens in the Irish social world. Having mapped the orientation towards state sponsored individualism within Irish social and economic policy, the impact of neoliberalism and its origins are obvious and its propagation via powerful media discourse is evident. Furthermore, this chapter has argued that the internalisation by the citizen of core principles and beliefs that surround neoliberal social policies contributes to a process of subjectivisation. The subjectivised citizen is silenced, is vulnerable to the vagaries of market forces and compelled to behave as a consumer; the role into which they have been cast. The state and other powerful actors may well benefit by such a process as the individualised nation has little capacity to organise and criticise while focused entirely on self-interested concerns in the market society. Indeed it could be argued that the current austerity regimens in countries such as Ireland, Spain and Greece have depended upon a prior construction of a subjectivised citizen. These are the testing grounds of the neoliberal revolution.

The previously constructed 'ideal type' citizen for the market society, the possessive individualist (Macpherson 1962), is the archetypal actor for times of austerity as they will individualise their responsibility and they are therefore likely to accept their 'lot'. A rich example of this persuasive manoeuvre was seen in 2010 when the Finance Minister at the time of the banking crisis in Ireland and the subsequent disastrous bank guarantee told viewers on the Irish national broadcaster 'We all partied' (O'Callaghan 2010). His comment attempted to liken the irresponsible lending and spending of his administration to the prolific borrowing and spending of the Irish citizen during the 'Celtic Tiger' boom years. This unlikely comparison appealed to the subjectivised citizens to reflect on their own consumer activities and to accept some responsibility for the state of the nation's finances. Whilst it is undoubtable that many citizens borrowed beyond their means and ambitions for homes and luxuries grew far beyond means, these pale into insignificance in comparison to the massive unsecured and arguably illegal lending habits of 'zombie banks' to their development

friends. The light-touch regulation that allowed such practices to proceed unchecked was a consequence of ultra minimal state involvement; a core tenet of neoliberalism and indeed its antecedent, classical liberalism.

Those who benefited least in times of plenty, and found themselves outside of the club of borrowers and spenders, are now likely to be those that are most harmed by the state's financial measures. There are increasing numbers of families in poverty and the level of demand on resources of charitable organisations is at an all time high (Browne 2012). For those excluded members of society, those outside of the club, those in poverty, the disciplinarian nature of the welfare state becomes more overt. They become subject to accusations of being work-shy, of 'sponging from the state', and incessant but inaccurate contentions surrounding welfare fraud result in having to constantly account for themselves. They are the welfare class who are non-members of the club but instead are subject to a disciplinary welfare state, as has been discussed in the last chapter.

Many commentators have expressed surprise at the lack of protest against unpopular measures such as austerity in Ireland (McDonald 2010; Reguly 2011) however, given the character of the subjectivised citizen who has individualised their conditions, this is not so remarkable. Furthermore, the skills and practices of critical analysis have traditionally not been nurtured in Irish education or in Irish social life. The national broadcaster is seen to shy away from thoroughly critical analysis of state practices and can be said to engage in dissemination of the neoliberal discourse. It is through these means that neoliberalism and its ideologies come to be so hegemonic, as is seen through Phelan's (2007) analysis of the discourse of neoliberalism in Irish media:

> '…it can clearly be understood as a case of neoliberal hegemony, as long as it is recognized that neoliberalism is hegemonically constituted through a plurality of (inter)discursive forms and rhetorical strategies that are typically articulated through a euphemized, national accent' (p.42).

Such strategies serve to endorse the neoliberal agenda through a media narrated process described by Springer (2010) as when 'neoliberal subjectivation and `everyday neoliberalism' are sanctioned and constructed through discursive formations' (p.940). Bourdieu (1998) describes this work of inculcation through a media drip-feed of 'the language which invades us: we absorb it as soon as we open a newspaper, as soon as we turn on the radio…' (p.31) which results in the current state of neoliberal hegemony:

> 'A whole set of presuppositions is being imposed as self-evident: it is taken for granted that maximum growth, and therefore productivity and competitiveness, are the ultimate and sole goal of human actions; or that economic forces cannot be resisted' (Bourdieu 1998, pp.30-31)

In the neoliberal state everyone is being disciplined in some manner but the subjectivised citizen is self-disciplining. A state that should protect its vulnerable citizens promotes subsidising individualism instead of decommodifying its welfare system. The specificities of Irish welfare state are such that a different level of analysis is required that moves away from the commodification-decommodification spectrum, and instead examines what it is that enables what is largely the absence of a welfare state to be tolerated. What are the values that are endorsed by this state when health care is so inequitable? The answers lie within the degree of individualisation and thereby subjectivisation that has been propagated via the neoliberal approach to social policies over many decades through state sponsored possessive individualism. Furthermore the answers lie within numerous events and ruptures in the genealogical history of Ireland's health and welfare story and, specifically, where the core concepts of solidarity, of the social contract and the altruistic features of the gift relationship, might have featured and might have been forever altered.

Chapter 4: Theoretical Framework

> 'Justice, and injustice are none of the faculties neither of the body, nor mind. If they were, they might be in a man that were alone in the world, as well as his senses, and passions. They are qualities that relate to men in society, not in solitude. It is consequent also to the same condition, that there be no propriety, no dominion, no mine and thine distinct; but only that to be every man's, that he can get; and for so long, as he can keep it'

(Hobbes, Leviathan 13.13)

Introduction

Neoliberal ideology, as has been discussed in the preceding chapters, promotes an abandonment of concepts of the collective or universal provision of welfare and instead it incentivises the private citizen who abandons a social contract to participate in the market and purchase health care. This strategy, not unlike past policies in the domain of housing in Ireland, results in a subsequent disappearance of a collective solidarity and thereby the subordination of citizens according to a hierarchy of status or class. There is no recognition of the value of altruism, and the gift relationship is devalued. The assumption that individuals recognise and respect the existence of a social contract, with inherent premises around solidarity and gifting to those less able or well off, no longer holds true. Furthermore, it can be seen that the features of 'possessive individualism', features essential in a capitalist economy, are visible in the current Irish social order.

This chapter will examine this critical perspective on Irish health care and will seek to place the debate on issues of solidarity and of collectivity, outlined in earlier chapters, within a theoretical framework. It will look to some key theorists to interrogate the current situation with health and welfare in contemporary Ireland as framed within the theories conceptualised by pivotal sociological, philosophical and anthropological writers. The emerging theoretical framework therefore, is focused on

the concepts of the social contract, the gift relationship, and possessive individualism, and will draw on the influential writings of Hobbes, Rousseau, Rawls, Durkheim, Mauss, Titmuss and Macpherson, to provide illumination of these concepts and to examine how, along with the connecting concept of justice, they might be brought to bear on this current societal issue.

The Social Contract and Civil Society

The concept of the social contract is one that has attracted much philosophical, political and sociological thought for many centuries. In the early 17th century Thomas Hobbes, in his seminal work "Leviathan", argues that for a society to be 'civil' and peaceful there is a need for an overseeing sovereign power charged with ensuring the wellbeing of citizens. Without surrendering power to such an entity the naturally competitive 'state of nature' would ensue and society would fall victim to the self-interested egoists with the subsequent eradication of altruism. The separation of political system and civil society, constituted by the sovereign power and subjects respectively, he argues, establishes the social contract (Ray 2004). Hobbes can be seen to have deduced his political theory having regard to his assumptions about innate human nature, that is that individuals are naturally self-serving and therefore need an overseeing sovereign power to control them, preventing mere satisfaction of individual desires. He warns that:

> 'In such condition there is no place for Industry, because the fruit thereof is uncertain: and consequently no Culture of the Earth; no Navigation, nor use of the commodities that may be imported by Sea; no commodious Building; no Instruments of moving, and removing such things as require much force; no Knowledge of the face of the Earth; no account of Time; no Arts; no Letters; no Society; and which is worst of all, continual fear and danger of violent death; And the life of man, solitary, poore, nasty, brutish, and short' (Hobbes 1968, p.186).

Civilised society is impossible then when the full state of nature is countenanced and man is possessed by competition, diffidence and glory. By establishing an overawing

sovereign power, derived from the consent of the governed, a social contract is constructed. The presence of such a contract should negate the need for man to exist in a state of perpetual competition and instead should promote the interests of the collective.

The subsequent nexus of the collective good versus the individual good remains critical more than one hundred years later when Jean Jacques Rousseau continues to expound the concept of the social contract. Referring to this 'moral and collective body' (Rousseau [1762] 1998 p.14), Rousseau argues that through such collectivism, as inferred by the social contract, man can ensure the survival of his own interests, his freedom and that of the larger society. It could be argued that this position places collective action in a less than purely altruistic light. Gourevitch (1997 p.xviii) describes participating in the social contract as our '…constantly renewed recognition of ourselves as members of a common political or civil society, and of how intimately intertwined our own good is with the common good'. However, it is just these intertwined notions of individual concerns and collective concerns that are of interest.

Bertram (2004) plainly distinguishes Rousseau's ideas on the consequences of engagement in a social contract from those of Hobbes and Locke. These earlier 17th century writers assigned what could be regarded as more self interested motivations to engage in civil society; that is, the concerns of the participants in the contract with their 'antecedent interests' (Bertram, 2004, p.81) or their mutual self interests. The Rousseauian description, on the other hand, of the man who commits to the social contract is one of a transition that is virtually transcendent in its description;

> '…he gains such great advantages in return, his faculties are exercised and developed, his ideas enlarged, his sentiments ennobled, his entire soul is elevated to such an extent, that if the abuses of the new condition did not often degrade him to beneath the condition he has left, he should ceaselessly bless the happy moment which wrested him from it forever, and out of a stupid and bounded animal made an intelligent being and a man' (1.8.1).

So Rousseau argues that the very essence of an individual is altered by their participation in a social contract within a civil state; he is guided now by wider altruistic notions rather than by instinct or impulse. Rousseau adds to this notion of the collective good when he states:

> 'So long as a number of men in combination are considered as a single body, they have but one will, which relates to the common preservation and to the general well-being' (4.1.1)

But to what extent can any altruistic or collective notions be considered to be just that? It can be argued that any actions or developments initiated with the common good in mind are ultimately to the benefit of the individual who forms a part of the community. If a society were made up entirely of self-serving individuals it would be short-lived; as each member of civilisation promoted their own interests they would soon tear their society apart. Thus the egoist would be bereft of a civil society in which to inhabit. So, it is to the benefit of the individual to cooperate with the social contract. Perhaps the converse could also be argued; the individual who concerns himself with self-maintenance and development surely lightens the burden of communal societal responsibility? This argument is unconvincing and is not supported by social contract theory, failing as it does to place a value on the strength of the societal whole, held together by, what Durkheim refers to as, social bonds (Durkheim 1984).

Nagle (1991) interprets the notions of individualism and collectivity in terms of the duality of standpoints; the 'personal' and the 'impersonal'. This division results in a continuous rebalancing of motives in order to achieve equilibrium. He describes the 'constant overlap of impersonally supported practices and individual aims, with the impersonal requiring us to restrict or inhibit the pursuit of the personal without giving it up' (p.25). Again, not unlike the theories proposed by Hobbes and Locke, there is an undercurrent of inherent self-preservation. Nagle accepts that consideration of the collective, by definition will inhibit the pursuit of our self-serving objectives. However,

he acknowledges that the pursuit of the personal will persist, not, however, to the detriment of the collective or the impersonal.

Returning to the concept of the social contract, it is important to consider it, not as a tangible social arrangement, so much as a hypothetical circumstance that enables related perceptions of justice. John Rawls is credited with reigniting contemporary debate surrounding the social contract in the second half of the 20th century with his, what some have called Kantian, conception of the social contract as related to justice. Rawls' theory of justice, at a higher level of abstraction than the 'familiar theory of the social contract' (Rawls 1971, p.11), asks what principles of justice man would include if he were given the opportunity to redesign society. Rawls considered man to need to employ both rational thoughts and interpretations of reasonableness in order to settle upon mutually agreeable social rules. From behind the 'veil of ignorance', he said, individuals can truly consider pure first principles of justice that are not tainted by their own interests and positions. Given that no individual enjoys the absence of preconceptions or prejudices that might be provided by the veil of ignorance, it can only be assumed that Rawls does not believe any of us capable of conceptualising true justice or fairness while without such a veil. Instead we view the world through a veil of self-absorption. He refers to the principles of justice as those that:

> '…free and rational persons concerned to further their own interest would accept in an initial position of equality as defining the fundamental terms of their association. This way of regarding the principles of justice I shall call justice as fairness' (p.11).

Rich (2000) describes a modern configuration in the US of the social contract as relating purely to the exchange, between citizen and state, of taxes in return for services. However, the inherent power imbalance in such a structure does not adhere to the social contract in a genuine sense. Furthermore, the citizen's sense of obligation to make such contributions is less as a result of a sense of social cohesion than it is related to the punitive measures that can be taken if their side of the social contract is not honoured.

Critics of Social Contract Theory

David Hume is one of a number of political philosophers who have questioned the very feasibility of the social contract. Cudd (2008) explains:

> '…Hume takes particular exception to the appeal to tacit consent…he protests, that most people have given their consent to obey the laws simply by remaining in their country of birth' (part 1.0).

Contractarianism is further questioned within the contexts of consent, religiosity, disability and normative notions of rationality. Jean Hampton (1988), for example, criticises the Hobbesian conception of the social contract pointing out that even if the purpose of the social contract is to overcome the self-serving inherent human qualities of passion and rationality, these qualities will still prevail after agreement to a social contract that is likely to have done little to prevent their dominance.

Further criticism of the social contract in terms of an arrangement between government and society has centred on the voluntary nature of such a contract. This was a particular criticism held by the political philosopher and abolitionist Lysander Spooner. If punishments and penalties exist for failing to honour a contract (for example a failure to pay taxes), then parties cannot truly be understood to have entered in to such a contract freely. Spooner went so far as to question the feasibility of assuming the allegiance of all men to the US Constitution, given that they had not all pledged such faith and therefore could not be assumed to be consenting members of this collective.

Social solidarity and social cohesion

Durkheim acknowledges the dual perspectives of individual consciousness and that of the collective stating in De la Division du Travail Social in 1893:

> 'There are in each one of us two forms of consciousness: one which is common to our group as a whole, which, consequently, is not ourself, but society living and acting within us; the other, on the other hand, represents that in us which is personal and distinct, that which makes us an individual' cited in (Giddens 1972, p.139).

Durkheim deplored 'the effects of unfettered individualism' (Douglas 1990 p.xvi) and it was from this standpoint that he developed his theory on the division of labour and social differentiation. He refers to what he calls mechanical solidarity and organic solidarity and it is through this theory that he examines the concept of social cohesion. He regarded the social division of labour as being critical to the creation of social links and bonds, without which society would break down and suffer from anomic isolation.

He describes mechanical solidarity as based merely on coincidental notions of similarity and resemblances within the horde. The more valued organic solidarity, however, engages the individuals in 'recurring cooperative relations with others who are involved in different but complementary activities' (Pearce 1989, p.62). Critics of Durkheim's position on organic solidarity suggest that he fails to address adequately the issue of class relations and their dynamic relations to solidarity and the division of labour (Lockwood 1992). He was instead more concerned with the utilisation of legal means of overcoming what he saw as the legitimation of natural inequalities. 'Durkheim saw legal rights as embodying beliefs and values which were in turn expressive of a certain state of social solidarity' (Lockwood, 1992, p.82).

Social solidarity of the organic type described by Durkheim focuses on the notion of interdependency of individuals within a community. Each citizen, realising their inability to succeed alone seeks binding relations that will be to the benefit of all. This 'Obligation of Solidarity' is epitomised by Beck & Beck-Gernsheim (2002) as existing in an exemplified form within pre-industrial rural agricultural communities. 'It was a

tightly knit community, in which little room was left for personal inclinations, feelings and motives. What counted was not the individual person but common goals and purposes' (Beck & Beck-Gernsheim, 2002, p. 88). They go on to cite Borscheid (1988) who referred to this as a 'community of need' bound by an 'obligation of solidarity'.

However, the traditionally structured family and community illustrated by Beck & Beck-Gernsheim rarely exists in this true form, but their illustration could be extended to refer to social constructs such as the welfare state. There is here a notion of interdependency, sharing equivalent features of Durkheim's organic solidarity. Instead of the direct input of members of a community, the welfare state creates an opportunity for taxpayers to support the state in providing a minimum of welfare and protection to its citizens; an instantiation of solidarity.

The Gift Exchange

As a nephew of Durkheim, Marcel Mauss was well placed to expand and fuse the domains of sociological investigation with anthropological studies. His crucial work, the title of which translates to 'The Gift: The Form and Reason for Exchange in Archaic Societies', originally published as an essay in L'Année Sociologique in 1925, and subsequently translated and published numerous times, conceptualises the notion of societal systems of exchange as on-going, unfolding relations of reciprocity. He relied heavily on his vast knowledge of language and customs in primitive societies in his explication of exchanges that have been described as being all at once 'economic, juridicial, moral, aesthetic, religious, mythological and socio-morphological phenomena' (Evans-Pritchard 1966 p.vii). Mauss theorised that it is through instantiations of the gift exchange, and the inherent trust therein, that societies build their levels of solidarity. 'The gift can reveal something essential about what holds us together' (Godbout 2006). The gift relation is regarded therefore as a total social fact, or phenomenon, that involves the totality of society, and is closely related to the concept of solidarity. Mauss regarded the gift exchange as a case through which 'one can study the whole of human behaviour, and social life in its entirety' (Mauss 1990, p.107).

Mauss' theory of the gift also operates as 'a theory of human solidarity' (Douglas 1990 p.xiii) and the gift exchange functions as an immensely useful counterpoint to other types of exchange, such as the pure market exchange, or a state system. Mauss testifies to the forgotten facts that there is no 'natural' economy, that the market is a human phenomenon and that markets existed in these archaic forms long before merchants, currency and modern sale contracts as we currently understand them. However, in modernity the gift system has yielded its place to the industrial system (Douglas 1990).

He identified three specific obligations inherent in the gift exchange: to give, to receive and to reciprocate. These obligations, particularly the requital nature of the gift exchange, distinguish it from mere commercial activity which demands exact recompense. However, Douglas (1990) argues that the symbolic, interpersonal and economic associations within the gift exchange do allow comparison of it with the modern form of market economy.

Mauss makes a powerful case that points to the remnants of this total social phenomenon in contemporary interactions when he says: 'A considerable part of our morality and our lives themselves are still permeated with this same atmosphere of the gift, where obligation and liberty intermingle' (Mauss 1990, p.83). He goes on to emphasise a moral component to all exchanges that underlines the gift as a total social fact from which all other systems of exchange have flowed. In his effort to underline the morality of the exchange, he remains optimistic that the ancient and ethical basis on which contemporary exchanges originate will shine through. Furthermore, he seems to believe that the total social fact of the gift exchange enables a clearer understanding of human interactions in the social world.

> 'These facts not only throw light upon our morality and help to direct our ideals. In their light, we can analyse better the most general economic facts, and even this analysis helps us dimly to perceive better organisational procedures applicable in our societies' (Mauss 1990, p.91)

It is clear, therefore, that Mauss believes a retrospective anthropological perspective on an ancient pre-market social system of reciprocity to be vital to a full understanding of, and indeed the betterment of, contemporary industrial economic systems.

Furthermore, Mauss indicates the sustained relevance within what might otherwise be considered a mere mechanical exchange of goods. The gift exchange incorporates more aesthetic, human, ethical and moral dimensions than a mere economical system.

> 'He had no doubt at the end of The Gift about the worth of ancient moral values, such as charity, and he put forward a morality based on solidarity and reciprocity' (Fournier 2007, p.112).

Mauss concludes that, while the turning of Western individuals into economic animals was a recent phenomenon, ('It is our western societies who have recently made man an "economic animal". But we are not yet all creatures of this genus' Mauss 1990, p.98), there was, at that time, still potential to save society through endorsement of ancient values. He refers to innovative interventions by industrialists to provide funds for the families of their workers as acknowledging their responsibilities in the context of the gift exchange. He goes on to describe the establishment of group compensation funds and mutual societies as 'the dawning, and even the realisation, of professional morality and corporate law' (Mauss 1990, p.87), in other words a 'returning to a group morality' (p.87).

This seminal research by Mauss remains highly relevant in contemporary debates surrounding societal obligations and individual entitlements, as he had discovered 'a mechanism by which individual interests combine to make a social system, without engaging in market exchange' (Douglas 1990 p.xviii). Additionally, in a time of retrenched welfare statism it remains pertinent to utilise his theory of the gift to contextualise social democracy recalling, as Douglas (1990) does, that 'social security and health insurance are an expression of solidarity' (p.xix). Most crucially,

Mauss emphasised at the end of 'The Gift' the totalising nature of the gift as not just an economic fact, but as a total social fact:

> 'There is no other morality, nor any other form of economy, nor any other social practices save these. […] In this way nations today can make themselves strong and rich, happy and good' (Mauss 1990, p.106)

The Gift Relationship

Richard Titmuss, considered by many as a founder of the academic study of social policy, was concerned in much of his work with social justice, inequalities and how these related to health and welfare concerns. His influential text published a few years before his death The Gift Relationship: From Human Blood to Social Policy (1970) examined the concept of altruism through the exemplar of blood donations. He analysed altruism and the gift exchange surrounding voluntary blood donation in the UK, contrasting it against the system of remunerated blood donation in the US. Titmuss used the anthropological works of Mauss and Levi-Strauss in his scrutiny of what he saw as an exchange rich in social obligation and compulsion. Many of the conclusions drawn focus on the need for individuals to have the personal freedom to choose to be altruistic and on the role of policy, free from market forces, in facilitating such choice:

> '…the true nature of the choices in the social policy field […] is not made apparent by those who advocate the extension of market behaviour to medical care, blood transfusion services, education and other instruments of the 'social'. Choice cannot be abstracted from its social context, its values and disvalues, and measured in 'value free' forms' (Titmuss 1970, p.243).

His obvious disgust at the prevailing encroachment of economic factors into health and welfare and the potential for the 'possessive egoism of the market place' to oppose altruism is laudable. Pinker (2006) describes the relationship of this work by Titmuss to the bigger picture of social wellbeing and welfare, stating:

> 'Titmuss was convinced that the statutory social services, in general, and the voluntary giving of blood, in particular, fostered social integration and encouraged the growth of altruism more effectively than any other system of welfare provision' (p.15).

So in effect Titmuss believed it was the role of social policy to seek to change the human nature that tended towards egoism. While he referred to 'choice' in the context of true altruism in the social market, Titmuss described the egoism of the economic market as compulsory and thereby leaving participants without choice. This conception of the role of policy differs from the view of the current occupant of the Chair of Social Policy at LSE (first held by Richard Titmuss) Professor Julian Le Grand. As a prolific writer on issues relating to welfare and social policy and a former advisor to the Blair government, Le Grand believes that the design and implementation of social policies have key roles to play in harnessing both altruism and egoism in a positive manner. Unlike Titmuss who sought to overcome naturally present egoistic tendencies, Le Grand promotes a more pluralistic approach that acknowledges the reality of human nature (Le Grand 2003; Pinker 2006) .

Possessive Individualism

The qualities of human nature were also of interest to the political theorist Professor C. B. Macpherson who examined the ontology of liberal democratic theory, and identified Possessive Individualism as the key political philosophy of capitalist societies. His seminal text 'The Political Theory of Possessive Individualism' (1962) examined the lineage of political thought from Hobbes and Locke, from where he demonstrated the origins of twentieth century conceptions of freedom and obligation had emerged. Identifying that man is the proprietor of his own person and his labours and 'what makes a man human is freedom from dependence on the will of others' (p.263), he argued that the assumptions fundamental to such conceptions were inherently rooted in market societies and capitalist regimes:

> 'I shall argue that these assumptions which do correspond substantially to the actual relations of a market society, were what gave liberal theory its strength…' (p.4).

Macpherson contends though that the philosophical theories built on these bourgeois assumptions are, by virtue of their immersion in the context of a capitalist market society, 'ill suited to recognise or critique these assumptions' (Little 2011, http://understandingsociety.blogspot.ie/2011/08/possessive-individualism.html Accessed 23rd March 2013). Macpherson draws on Hobbes' models of societies, identifying the 'Possessive Market Society' as corresponding to modern market societies. In this society man's labour, his energies and his skills have become marketable commodities. Such a focus on commodification permeates every area of the social world and as a result obscures 'deeper human purposes and capacities' (Carens 1993, p.3). Macpherson's analysis of Hobbes and Locke seeks to 'expose the possessive individualist roots of modern liberalism, by revealing what can be called its 'negative ontology' (Townshend 2000, p.17). It is impossible, Macpherson contends, for the Hobbesian interpretation of social relations to be regarded as dispassionate as it relied heavily on the existence of a capitalist society in which the assumption was that the:

> 'individual is human qua proprietor of his own person, that the human essence is freedom from any but self interested contractual relations with others, and that society is essentially a series of market relations between these free individuals' (Macpherson 1973, p.158).

Such an interpretation of society reduces human interactions to mere market exchanges focused on the pursuit of acquisitions and consumption. Hobbes, contends Macpherson, '… saw all human attributes as commodities, to be contracted for and exchanged at values set by the impersonal operation of a market in power, and who reduced justice to the performance of a contract' (Macpherson 1973, p.193). For these reasons, Macpherson argues, possessive individualism is flawed as it 'generates an impoverished view of life….obscuring deeper human purposes and capacities' (Carens 1993, p.3).

However, possessive individualism has become established as the political philosophy of capitalist societies as it promotes individuals to seek ownership of

commodities, including ownership of the means of production. Inevitably this creates a concentration of dominance among those in possession of such means and consequently others are forced to sell their only commodity; their labour. Thus, possessive individualism as a function of the capitalist system results in a hierarchy of those with a capacity to sell their labour being subordinate to those owners of property, commodities and the means of production. The significant inequalities resulting from this system is described by Carens;

> 'The possessive individualist version of democracy denies and conceals the oppression and class domination inherent in a society based upon private — and unequal — property' (1993, p.3).

Macpherson affirms the socially divisive effects of possessive individualism and the capitalist market economy as it succeeds in creating '…a dominant and a subservient class, and freedom for the former was domination over the latter' (Macpherson 1973, p.200). Margaret Thatcher emphasised the importance she placed on property in relation to freedom in the 1970s in the UK when she stated:
'If a Tory does not believe that private property is one of the main bulwarks of individual freedom, then he had better become a socialist and have done with it' (Thatcher 1975).

Applying Social Contract Theory

Does social contract theory contain potential to reinvent the central concepts of justice and solidarity so as to have relevance for solving contemporary problems surrounding health and welfare? D'Agostino and Gaus (2008) posit:

> '…the question for contemporary hypothetical contract theories is whether the hypothetical agreement of your surrogate tracks your reasons to accept social arrangements'

(Available at http://plato.stanford.edu/archives/win2008/entries/contractarianism-sontemporary/).
It could be argued that if surrogates were to accurately reflect the wishes of Irish society regarding, say, the social arrangements of health care in Ireland, they would

struggle to track back the societal acceptance of the current arrangements. Whilst there is much history to account for our current health and welfare systems, including the influence of church and charitable organisations as well as the dominance of consultant driven health care, more contemporary economic and political influencing factors have also been relevant. The dynamic fortunes of the country's fiscal status have been partnered by strongly influential neoliberalism, whose hegemonic ideology has succeeded in infiltrating Ireland's health and welfare policies. But not only do government policies reflect a shift from consideration of the public good as a priority, but the prevailing social perceptions of obligations to ensure social arrangements that meet health or welfare needs of those in need, have been actively eroded. It could be argued that Irish society has consequently lost its capacity for a sense of collective justice and thereby fails to insist on the correction of existing unjust social arrangements. What is very clear, however, is that an examination of the past circumstances that have contributed to current circumstances is essential to allow a deeper understanding.

D'Agostino and Gaus (2008) identify the issue of justification of obligations to the social contract and therefore they challenge the reader to identify 'what principles can be justified to all reasonable citizens or persons?' (p. 6). How could a contemporary fabrication of a social contract identify that which all reasonable citizens would agree as fundamental ingredients? If we were to concern ourselves with the fashioning of a new social contract that would address the health and welfare of Irish citizens, what current understandings of principles of justice would necessarily be included? What would we jointly will if we were all free and equal citizens?

Perhaps the use of moral language might aid in identifying potentially valued contemporary principles of justice; concepts such as justice, equality, fairness, beneficence, veracity and prudence might feature strongly in a redrawing of a social contract. However, recent events in Irish political and banking domains have resulted in an erosion of trust, an essential ingredient in any contractual agreement. The presence of significant levels of distrust in political and policy activities do little to strengthen feelings of solidarity. A contract drawn up in the absence of trust is likely to be one riddled with defensive clauses. How can such trust be won back? The history of welfare states often tells of times when extreme hardships and

catastrophic economic events become catalysts for progress. Ginsburg (1992) suggests that many aspects of social policy reform have been effected in the most challenging of times.

> 'At moments of crisis, states have sometimes seized upon social policy reform in the attempt to engineer national solidarity – Bismark in the 1880s, the Swedish Social Democrats in the 1930s, the Beveridge Report, Johnsons Great Society programmes of the 1960s' (p.10).

In post-war Britain the levels of social solidarity generated by the 'blitz spirit' created an environment rich for the establishment of societal agreements between state and citizen. As each family had paid the high price of the lives of many of their sons in battle, there was a common understanding that brought policy maker and policy recipient to an equal level with strong levels of trust. In 2013 the filmmaker Ken Loach produced a documentary that sought to capture that which was particular about this period in his film The Spirit of '45, in which he celebrates the 'period of unprecedented community spirit' and the momentous developments that were at the centre of the creation of the Beveridgian welfare state. Demonstrating how different Britain would be if the events of 1945 had not taken place and using survey data to show how life was for the British people in 1945, Loach asks whether it might yet be possible to recreate the spirit of '45 in contemporary Britain (Loach 2013).

The current financial crisis, however, is likely to have eroded levels of social trust, an ingredient necessary to establish social capital and to endorse a well-funded welfare system (Jensen & Svendsen 2009).

> 'We use social trust as the standard measure for this ability to cooperate because it expresses how people estimate the risk of being cheated in a society' (Svensden 2011 blog).

In order to re-establish a new social contract for contemporary Irish health and welfare, we should seek to measure and invest in our social capital and to nurture perceptions of social trust.

Applying Social Solidarity and Social Cohesion

Socially divisive effects of neoliberal ideologies have not gone undocumented. David Harvey (2007) warns that neoliberalism and the attendant

> 'drive towards market freedoms and the commodification of everything can all too easily run amok and produce social incoherence. The destruction of forms of social solidarity and even, as Thatcher suggested, of the very idea of society itself, leaves a gaping hole in the social order'(p.80).

In applying this understanding of the effects of neoliberalism on health care we can easily see the resultant impact of market forces and the re-conceptualisation of health care as a commodity (CSDH 2008). A number of forces have been at work to create this impact. Primarily the influx of private companies to the health care market in Ireland, incentivised by tax breaks, has created further distraction from the underlying issue of an under-resourced public health system (Burke 2010). Patients have become clients; indeed they are customers and consumers. The Irish public have been sold a right to 'choose' their health care, when in actual fact they have been persuaded to pay privately for such a choice and to ignore the fact that the choice should rightly be provided to them and to everyone else in the state. Meanwhile, quietly, the public system is run down and gradually becomes regarded, often erroneously, as of inferior quality to privately funded health care (Wren 2003). As a direct consequence, there is little commitment now to the role of public health care funded by the common social contributions; that is to say, a Durkheimian reification of organic solidarity (Dew 2007; Durkhiem 1984) has been neglected. If one does not 'need' the publicly funded health system then there is little interdependency between a person and other citizens. On the contrary, the divisive nature of prevailing self-determinance results in what Durkheim referred to as societal rivalry. A sense of status is conferred on one who has private health insurance leading to the creation of tiers of entitlement within the provision of basic health needs. The separation of the public and the private is not just theoretical it is physical. For example, recent policy to co-locate private hospitals on the grounds of public facilities is demonstrative of an intention to leech services and expertise from

the public sector while concurrently creating a physical barrier between those who have and have not. There is no possibility of a sense of the collective nature of a health system so long as health care is provided in the equivalent of gated residences. Without such interactive connectedness, social cohesion is at risk and solidarity cannot be realised. Ironically, a loss of social cohesion is known to directly impact on the health and wellbeing of citizens (Kawachi et al. 1999).

What would a contemporary application of Durkheim's theories of social cohesion and social solidarity look like and what features would be requisite? Irish history is rich with features that are of relevance to these theories. The recurrent and prolonged struggles against invading forces, the status as an island nation, the dearly held neutrality in global warfare and a long history of strong agricultural communities could all be regarded as of relevance to cohesion and solidarity. The history of Ireland's health system contains events and developments of specific relevance including the role of the church in health care provision, the charitable status of many hospitals and the patriarchal model of medicine. In the past churches and charities were seen to have the responsibility of providing care for the weak and the sick. Members of society play their part by making voluntary donations to church and charitable funds, thus feeding their perceptions of a sense of solidarity with those in need. Some have argued, however, that welfare provision has eroded the role of charitable organisations and thus the opportunity for altruistic acts (Le Grand 2003). What is crucial is that we look to history to aid us to understand the processes that have created the present. The creation of conditions suitable for engendering social solidarity and cohesion demands that a sense of the collective be assimilated by Irish society, ideally in the form of a critical common purpose. An ultimate objective that is to the benefit of all citizens is another crucial feature. The challenge here is enormous as having enjoyed a semblance of inflated fallacious wealth much of Irish society has been fed a diet of neoliberal ideology that emphasises the focus on the individual. A sense of concern for fellow man will have to be relearned.

Applying the Gift Relation and Altruism

How does the current sociological make up of Ireland exemplify the reciprocal agreement inherent in the gift relation? The work of Titmuss centred around the

assumption that it was morally offensive for the poor to sell their blood to the rich, however it could be argued that Ireland's health care demonstrates a comparable degree of moral insult. What exchanges or acts of altruism are seen to be of value to civil society? In many ways Ireland's financial crisis could be seen to have had damaging effects on the gift relation. Bankers and property developers, for example, have been seen to fail in their obligation to repay, one of three fundamental obligations (along with the obligations to give and to receive) that Mauss identified as critical to the gift exchange. Consequently the gift relation, this fundamental social phenomenon has been corrupted. Mauss believed that the gift exchange was 'underpinned by a powerful sense of obligation to reciprocate the original gift' (Abercrombie et al. 2006, p.166). So in order to re-establish the formal gift exchange as an instrument to endorse solidarity, it is crucial that the reciprocal nature of the exchange is held true. This may take the form of public acknowledgments of a failure to honour the reciprocation of exchanges. Small businesses are closing their doors as banks, which previously engaged in exchange, now refuse to reciprocate in the form of extensions of credit. Those employers forced to let staff go may also be interpreted as failing to engage in the completion of their obligations to their workers. These workers now rely on the safety net of an eroded welfare state to prevent the destitution of their family. The moral pillar of all exchanges, flowing as they do from the social fact of the gift exchange, cannot be seen to have been honoured in this case.

The potential role of social policy makers in the re-establishment of altruism in Irish life should not be underestimated. Pinker (2006) refers to the role of policy makers in terms of the maintenance of altruism:

> 'Good social policies ought, therefore, to be designed to complement and reinforce the qualities of interdependence and reciprocity' (p.18).

A key instrument of social policy in Ireland, like many western nations, is the welfare state, or, what remains of it. Critics have accused the welfare state however of 'stressing social rights at the cost of ignoring social and moral obligations' (Fitzpatrick 2005, p.10). The welfare state, in its disciplinarian form, the left might

argue, has moved far away from an altruistic structure that epitomises the reciprocity of the gift relationship. Meanwhile, those on the right argue that the welfare state does little to encourage self-reliance or autonomy, that it results in moral atrophy and that it instead serves to foster dependency. Independence and self-actualisation, the neoliberal argues, provides choice and autonomous decision-making. This freedom to make a personal choice is mislabelled in the context of health care and is manifested in the promotion of private health care and the enticement of the citizen to place their health in the hands of the market. Supporters of the welfare state, on the other hand, do so because they 'approve the moral purpose of the welfare state programmes' (Mau 2004, p.67).

The gift relationship is sociologically important because of its contribution to social cohesion. The role of welfare as well as other social policies in reaffirming the gift relationship and thereby securing a more stable future for social cohesion is therefore a significant one. There is a tension, however, between the utilitarian approach, used as the main analytical tool of policy making in the neoliberal context, and the approach that seeks to apply the theory of the gift as we understand it today.

Applying the political theory of Possessive Individualism

Macpherson had clearly identified that possessive individualism, with its ontological roots firmly in capitalist society, had the effect of reducing many human relations to little more than market exchanges. He identified the origins of this with 17th century political philosophers and their environs but, more interestingly for this thesis, he discerned the direct consequence of such individualism as concealed class domination. Such class domination can be seen in the case of Ireland's health care system and in the powerful private health care industry. 'The market relation was not a free one', said Macpherson 'but concealed class domination' (1973, p.200). Such class domination to which Macpherson refers can be seen in public hospital waiting rooms up and down this and other countries. Here the subordinate, poorer, sicker and more vulnerable members of society are corralled into inadequate spaces with little choice but to resume their wait for untimely and undignified treatment. Meanwhile the dominant class members have undergone no such humiliation and are fast tracked into plush facilities, the access to which they have purchased by

virtue of their status as consumers and their subsequent engagement with the market. Their relationship with their health care provider is one that is mediated by their health insurance company, a company that is involved in this exchange by virtue of its competitiveness in the market, and of its success in selling to this dominant citizen the commodity of a health insurance policy.

Wider policy decisions have also contributed to these circumstances. As outlined in Chapters 2 and 3, the strongly influential wave of neoliberal policy decisions has elevated the status of market forces in health care to a commanding position, both in Ireland and many other countries. In the US, for example:

> 'a lack of health insurance is associated with substandard medical care and with increased risk of subsequent morbidity and mortality' (Muntaner & Parsons 2005, p.301).

And those with private health insurance can be predicted by social factors such as employment, income, wealth and social status.

Conclusion

The central theoretical themes of this chapter have been those of solidarity and altruism as manifested through the heuristic devices of the gift relationship and the social contract. In addition, the concept of possessive individualism can be seen to hold a central position. All of these concepts are inextricably linked in three ways; they all relate to the central concept of justice, they all have a role as potential panaceas for contemporary societal difficulties, but also they are linked in their shared vulnerability. Has the social contract broken down? At what point does repeated visible inequality become unacceptable? Is the concept of reciprocity adequately articulated in discourse on the welfare state? Is there a place for altruism in a world dominated by market forces? These are questions that must be addressed by social theoretical exploration as well as by social policy makers. But the buy-in of the citizen is clearly a crucial element. A system of gift exchanges that requires the intentional and altruistic input of individuals in a society will only be successful with accountability and clarity at its core.

The strength of much of the theory from the seminal writers referred to in this chapter is their endurance over many years, in some cases centuries. In many ways, very little has changed but the environment and the nature in which the demands for fairness and justice are claimed. Contemporary Ireland has significant social, economic and political challenges to overcome but in the midst of the commotion of recovery the voice of the vulnerable is often muted. For many who campaign for social justice in Ireland, new strategies and policies are premature if questions remain about who in the political and banking elite, for example, is responsible for the current crisis, and crucially if those responsible are not seen to have fulfilled their obligation to engage in a fair exchange.

Calls for transparency and restitution in the past in Ireland, however, have often been equated to lengthy and expensive legal tribunals: hardly a demonstration of true justice when funded by the tax of the wronged citizens. Is justice merely a reward for those enabled to seek legal and monetary retribution? What of those who cannot articulate the injustices they endure? Do they fall-foul of a system of justice operating in, what might be termed, an articulocracy? Finn and Hardiman (2011) support the hypothesis that just such a capacity to articulate needs is influential of policy makers' decisions within the realm of health care, saying:

> 'It may be that those who opt for private insurance are among the most affluent and articulate and are more successful at political lobbying than other groups. Since better public services and shorter waiting lists are not a priority for them, political pressure on these issues is reduced, and electoral and lobbying support for private sector alternatives is correspondingly strengthened' (p.6-7).

Co-operation between the state and the individual must be seen to be respecting the social contract and meeting the obligations, as well as the entitlements, of all parties, particularly the most vulnerable. Neoliberalism challenges the welfare consensus and has launched an attack on fundamental values and principles vital to the maintenance of solidarity and social cohesion. Citizens are unconvinced that

they need each other and they should know that to consider oneself as an isolated entity is ruinous. Instead a new construction of a social contract is needed which focuses on investment in the social infrastructure required to endorse social solidarity, with justice and openness at its nucleus.

In order to identify the means by which these central themes speak to issues surrounding Ireland's health care and welfare systems, this thesis will engage in a genealogical historical analysis of a number of critical antecedent events. Foucault's genealogical approach is immensely appropriate as it recognises and critiques the assumptions found in dominant discourses and seeks to examine motives, purposes and struggles therein. It is its subversive characteristic therefore, that makes Foucault's genealogy a vital instrument in challenging social assumptions and hegemonies.

Chapter 5: A Historical Genealogical Approach

Introduction

The purpose of this research is to examine the context in which an unequal system of health care has emerged and has become established and normalised in Ireland. The intention is to interrogate evidence within Ireland's health and welfare history so as to indicate the formative influences or early traces of our present situation. This evidence will be traced against the core concepts of the social contract and the gift relationship, as they can be seen to relate to solidarity, in an era of increasing possessive individualism. The history of Ireland's health care policy is rich with events, developments, policy decisions, transformations, scandals and some success stories, all of which serve to form a history of the present conditions. These present conditions, as discussed in Chapter 1, while deeply inequitable and unjust have not emerged suddenly as a consequence of radical policy making, but instead have gradually unfolded over many years as a result of a whole series of complex relations and discourses. Furthermore, the evolution of this unjust system has gone largely unnoticed by many, with virtually no substantial claims for an alternative system to be put in place.

Distinct and measurable health inequalities have been shown to persist in Ireland, as documented elsewhere in this thesis. The concern of this research with health inequalities is precisely how it has become regarded as normal that public patients without health insurance languish on waiting lists while those with insurance purchase timely lifesaving treatments. This research, therefore, seeks to uncover the origins and development of societal acceptance of an unequal health care system, and its inherent health inequalities, and aims to examine the implications of this acceptance for the social contract and for social solidarity. Given this retrospective approach, that seeks to trace the foundations of current circumstances, a historical approach is most appropriate.

Further subordinate research questions also present themselves in light of core theoretical concepts outlined in the previous chapter, such as; Why, and how, have

we compromised on the ideal state, distorting the social contract that provides for its weakest members? Does the neoliberal agenda cause us to re-imagine the social contract with a focus largely on individual responsibility instead of on a just welfare state? How is the collective conceptualised in contemporary Irish society? Where is the gift relationship situated in contemporary Ireland? Is there a residual role for altruism and solidarity? How has the discourse of politics and policy influenced collectivism and altruism? How do justice and fairness feature? In order to address these questions, this research will employ a historical examination of Irish health care informed by Foucault's genealogical approach. Foucault's historical technique examines what has hitherto been taken for granted and is therefore fitting for this examination of Ireland's entrenched two tier health care system.

Using a Foucauldian genealogical historical analysis for this research requires a systematic study of the development of health care and its associated ideologies and this is achieved through the use of four key case studies from Irish health care history. This approach seeks to recognise the 'continuities' and 'discontinuities' that are identifiable in the genealogy of Ireland's health care system (Salvatore 2007). A genealogy typically starts with a question about the present and works its way backwards and for this reason a genealogical approach to the problem of Ireland's health care, is particularly useful. A genealogy:

> 'aims at exploring the historical development of various processes, procedures and apparatuses whereby truth, knowledge and belief are produced' (Björnsdóttir 2002, p.5).

This chapter will set out the historical approaches championed by Foucault and will focus on his genealogical method. Some insights will be shown into Foucault's use of historical methods in his analyses of criminal justice systems and psychiatric medicine for example. Within these works core issues of knowledge, power and discourse feature strongly and will continue to resonate in this thesis in the context of Ireland's health and welfare system. The suitability of a genealogical approach to this research will be explicated within this chapter, as will the justification for the selection of this method.

Foucault, Genealogy & Archaeology

Much of Foucault's approach to history represented a significant departure from that of traditional historians in a number of ways. One feature is that he does not seek to establish a 'meta-history' or an overarching total explanatory history that provides linear or progressive patterns of events in an epoch. Instead he breaks from such a historicist view and in his archaeology emphasises what he calls the 'general history' which:

> '…eschews the totalising theme, concentrating instead on describing differences, transformations, continuities, mutations and so forth' (Kendall & Wickham 1999, p.24).

Foucault's historical approach included 'archaeologies' and 'genealogies' as conceptual and methodological building blocks. In his archaeologies Foucault sought, through his philosophical historical approach, to explore discursive formations that indicate the origins of, for example, medicine in The History of Madness (Foucault 1961), of contemporary health and physical illness in The Birth of the Clinic (Foucault 1963), of the history of science in The Order of Things (Foucault 1966) and an archaeology of discourse in The Archaeology of Knowledge (Foucault 1969). Foucault's earlier archaeological work provided an alternative to the previously popular conventional approaches utilised by sociologists and instead borrowed from those of the French structuralist movement. Rather than examining the new and the unfamiliar he sought to look at the familiar, so as to reveal our previously held assumptions (Baert 1998).

Later, Foucault moved away from this archaeological method and even went so far as to refer to these earlier works as 'imperfect sketches' of the archaeological form (Gutting 2003, p.4). His later work employed instead a genealogical approach in his study of punishment, Discipline and Punish (Foucault 1977), and of sexuality in The History of Sexuality (Foucault 1978). These genealogies are seen to have been influenced by the work of Friedrich Nietzsche in terms of the absence of a distinct intelligible world and instead the presence of what we have imposed (Moses & Knutsen 2007). Foucault's historical and philosophical approach to examining

phenomena of the present sought to identify the means by which the surrounding power, knowledge, truth and values of the phenomenon changed and evolved over time so as to create the conditions of their possibility. In this way Foucault's writing takes on a 'Nietzschean tenor' (Flynn 2003, p.32).

Mukerji (2007), in an examination of cultural genealogy relates how both Nietzsche and Foucault 'focus on the social roots and political consequences of on-going cultural forms' (p.51). However, she goes on to differentiate their approaches suggesting that while Foucault was concerned with 'classificatory politics', Nietzsche's approach differed from Foucault's saying:

> 'Nietzsche, in contrast, is more concerned with memory and self-consciousness – the loss of the past entailed in the construction of historical narratives that allows traditions to carry unnamed and hence unchallenged powers into the present. Nietzsche's genealogy treats temporal change in social life as more complex and problematic; what is left unsaid and yet done over time both evades and still shapes discourse through practice' (p.52).

This interpretation is one that resonates deeply within Ireland's health system in the sense that substantially unchallenged powers have resulted in the construction of particular narratives around issues like health care, individual responsibility, state obligations, the role of charities, for example, and the history of these narratives, along with 'what is left unsaid' (Mukerji 2007, p.52), have shaped both practice and discourse.

Problems and Contingencies

Foucault's approach to history is distinctive from other approaches for many reasons, but one distinction of significance for this study is his focus on a problem for investigation rather than a particular historical period (Kendall & Wickham 1999). This feature of Foucault's historical approach contributes to its suitability in the case of this research having, as it does, the problem of Ireland's unequal health care

system as the focus of investigation. Additionally, he described the value of examining events as 'contingencies'. However, as a champion of non-event-orientated histories he had a very unique conception of the term 'event' which he said:

> '…is not a decision, a treaty, a reign, or a battle, but the reversal of a relationship of forces, the usurpation of power, the appropriation of a vocabulary turned against those who had once used it..' (Foucault 1984, p.88)

Crucial relationships of force, along with the presence of power, and the use of a particular nomenclature, are fundamental features within the history of Ireland's health care, thereby providing a rich source of contingencies ripe for Foucauldian genealogy. For the purpose of this research, the 'problem' of Ireland's inequitable health care system, along with the commonly held assumptions and understandings of health care in Ireland, will be examined without limitations of a particular period. The contingencies to which Foucault refers will be identified and examined, along with their surrounding discourses, rather than seeking to apportion causal conclusions. Kendall & Wickham (1999) interpret this technique:

> 'When we describe an historical event as contingent, what we mean is that the emergence of that event was not necessary, but was one possible result of a whole series of complex relations between other events' (Kendall & Wickham 1999, p.5).

The history of Irish health care is strewn with examples of historical events, or contingencies as Foucault refers to them, that were significant in the manner in which discourses continued thereafter. These events can be seen as watershed moments that altered the circumstances in which various discourses emerged. Subsequent discourses, thus altered, have provided the conditions for current circumstances. Thus Foucault's genealogical approach is appropriate for this research as it does not seek to necessarily search for origins, but rather a recognition of the accidents and contingencies that have resulted in the present

conditions (Galvin 2002). Foucault refers to this approach as a History of the Present the value of which he makes clear when he said:

> 'recourse to history […] is meaningful to the extent that history serves to show how that-which-is has not always been; i.e., that the things which seem most evident to us are always formed in the confluence of encounters and chances, during the course of a precarious and fragile history' (Foucault 1988, p.37).

History of the Present

Foucault advocated the use of history, therefore, to diagnose the present circumstances. He suggests that we should seek to 'use it, deform it, to make it groan and protest' (Foucault 1977, p.10). By examining phenomena through a historical Foucauldian lens we have the opportunity to question what has been familiar to us; as Kendall and Wickham (1999) argue 'History should be used not to make ourselves comfortable, but rather to disturb the taken-for-granted' (p.4). Foucault's methods emphasise an archival examination of l'ensemble of discourses that provide the evidence of the conditions that prevailed and the relevant power relations within. Somers (Somers 2008) also endorses the use of a Foucauldian genealogy in this way as it 'aims to take up "minor" or repressed knowledge - not to reproduce dominant mythologies' (p.9). The challenging of dominant assumptions is undoubtedly an attractive defining characteristic of the genealogy. Gutting (2003) refers to this disruptive feature of the approach stating that:

> 'Foucault simply identifies genealogy with history of the present, regarding it as any effort to question the necessity of dominant categories and procedures. More narrowly, genealogy is a history of the present specifically concerned with the complex casual antecedents of a socio-intellectual reality' (p.12).

This approach is particularly useful for this study as the discourses surrounding health and health care are deeply embedded in social and political assumptions and are inherently linked to power, powerful actors and identifiable power relations. For

example, given the indivisible relations seen in Ireland's past between church and state and between church and health care, and the more contemporary relations between health care and the market, there exists a fascinating amalgam of acknowledged and unacknowledged power relations here. It is within their particular discourses that power relations can be seen to have emerged. But it is only by 'stepping back from this discourse, however, we can interrogate some of its underlying presuppositions' (Fraser & Gordon 1994, p.310).

Power

A genealogical approach can be applied to a wide range of research problems such as, a genealogy of dependency (Fraser & Gordon 1994), a genealogy of equality (Walker 2002), a genealogy of care-giving (Björnsdóttir 2002), a cultural genealogy (Mukerji 2007) or a queer genealogy (Doan 2013), for example. Many of these subject matters require a genealogical method because of the manner in which the researchers are seeking to challenge commonly held assumptions and wish to define the conditions that enabled these assumptions to take hold. Doan (2013) for example states that:

> 'Foucauldian genealogy is not interested in demonstrating historical truth; its objective is to determine the discursive conditions that contribute to the construction of what comes to be regarded as true' (p.85).

O'Farrell (1989) endorses this purpose of Foucault's approach as one that challenges current conditions despite, rather than because of powerful practices:
'The aim of Foucault's history is to show that our present is not the result of some historical necessity. It is instead the result of innumerable and very concrete human practices, and as such, can be changed by other practices' (p.39).

The research areas typically utilising a genealogical approach, such as those mentioned above, are related by virtue of the strong role that power plays within their subject matter. Power is a central feature in much of Foucault's writing, to the extent that in 1977 he said in an interview:

> 'When I think back now, I ask myself what else was I talking about in [The History of Madness] or The Birth of the Clinic, but power?' (Foucault 1980, p.115).

Foucault never goes so far as to define power but describes it as 'action upon the action of others' (Foucault1982b p.790) and he broadens the use of the concept to beyond its use as negatively pejorative (Flynn 2003). Walker (2002) explains that:

> '…power for Foucault was understood as a net or web of relationships, as something which "comes from everywhere", productive of truths, and requiring analysis its local configurations' (p.19).

In other words, Foucault's account of modern power is, as Fraser (1989b) suggests, 'productive rather than prohibitive' (p.18). However, power was not the sole focus of Foucault's work and many critics have made the mistake of misrepresenting Foucault as simply a theorist of power, despite the evidence that Szakolczai (1998) points to that shows; 'Foucault did not formulate a theory of power. Rather, his work was an on-going process of reflection' (Szakolczai 1998, p.1402). Foucault made this clear in 1982 when he said:

> 'The goal of my work during the last twenty years […] has not been to analyze the phenomenon of power, nor to elaborate the foundations of such an analysis. My objective, instead, has been to create a history of the different modes by which, in our culture, human beings are made subjects… Thus it is not power, but the subject, which is the general theme of my research' (Foucault 1982a p.208).

Hence it would appear that the relevance of power to Foucault's significant body of research is how it is used in relation to the process of subjectivation. Foucault's concern with power was the manner in which it is used in a disciplinary manner in order to achieve the domination and subjectivation of the citizen. The citizen has

become subject to powers and structures that, to a large extent, they are not conscious of, for example, as Baert (1998) explains:
'…structures tend to be taken for granted by the individuals who are subjected to them, and these structures are therefore unlikely to be visible to them' (p.122).
In precisely this manner, this research seeks to uncover the powerful disciplinary structures in Ireland's health and welfare systems, to which Irish citizens and patients have become subject. Much of this power is identifiable within the related discursivities, as much as it is in the equally telling silences that have succeeded in constituting a discourse in themselves.

Foucault hints at the manner in which discourse transmits indicators of power when he draws on Nietzsche's focus on who was speaking and who was designated to speak in his Genealogy of Morals:

> 'For it is there, in the holder of the discourse and, more profoundly still, in the possessor of the word, that language is gathered together in its entirety' (Foucault 1966, p.333).

The role of the speaker in genealogical examination is also endorsed by Walker (2002) who says:

> 'Genealogy explores why something is spoken about; who does the speaking; the positions they speak from; and the institutions that prompt them to speak, store and distribute what they say' (p.20).

Discourses

Foucault's attention to the richness of discourse as a site of power is a unique feature of much of his work. Discourse can encompass
'what can and cannot be known and said about a particular issue – what counts as knowledge and 'truth' in specific social and historical contexts' (Walker 2002, p.18).

The use of the term discourse is different here than in the realm of more traditional linguistic research. Foucault's conception of discourse was as a more potent site of

power relations or as regimes that impact on human conduct (Björnsdóttir, 2002). Such histories have a perpetual nature and are thus not bound by periods of time; he described discourse as '…the general system of the formation and transformation of statements' (Foucault 1969, p.146). So, in effect, he regards discourse not only as a site for examination of power relations, but also as an instrument of power wielding, an action as well as an outcome, so to speak. His historical approach involves the process of investigating the archives of such discourses (Kendall & Wickham 1999). Power (2011) describes these discourses very clearly:

> 'Statements or propositions (énoncés) are the basic units of discourse, and their totality comprises discursive formations that are the conditions of possibility of thought and hence of action. Specific discursive formations, or epistemes, create positions for subjects to occupy and in which they may be authorized to speak…' (p. 38).

Another useful description of what is meant by 'discourse' in Foucauldian terms comes from a paper by Ian Hunter (cited by Kendall & Wickham 1999):

> 'Foucault's histories are not histories of ideas, opinions or influences nor are they histories of the way in which economic, political and social contexts have shaped ideas or opinions. Rather they are reconstructions of the material conditions of thought or "knowledges" (p.35).

Discourses surrounding health care, for the purpose of this research, represent the corpus of organised and diverse spaces that have enabled the appearance of an understanding of the very concept of health care. This is made up of formal and informal knowledge from numerous domains. Pertinent discourses on health care have emerged from a broad range of sources and include both formal and informal sources. For example, health care policies (attempted policies as well as those successfully implemented), legislative documents relating to health care provisions, letters and commentaries in media of print, radio and television, results of opinion polls and surveys, mission statements of charitable organisations involved in health

care, of private hospitals and public hospitals, commercial advertising of health care products, reflections of political thinking evidenced in Dáil reports or other political materials, submissions by lobbyists to health care policy making bodies, statements made and opinions expressed by policy makers, the statements and opinions of people as health care users, the publications and websites of health care activist groups and the opinions expressed in informal online fora relating to health care and related politics. Such a wide range of discourses, many of which are examined in this thesis, serves to chronicle the emergence of influential contingencies (Foucault 1969) and all contribute to a rich tapestry of social opinion which enable the distinction of the early shoots of our contemporary situation.

Discontinuities and Contingencies in Irish Health care

It has been possible to identify key 'events' or points of 'rupture' in Irish health care, which have forever altered interpretations and knowledge within both the formal (connaissance) and the informal (savoir) domains of concept formation. For the purpose of this research a limited number of contingencies (4) have been chosen so as to allow sufficient depth of examination. These events, which have been instrumental in the transformation of the subject of Irish health care into it's currently individualised form, will be considered systematically so as to illuminate the questions posed earlier. Some of these events have become almost metaphorical instruments in illustrating the failures of Ireland's health care and, more specifically, the manner in which the discourse has validated Irish conceptions of justice and fairness, of reciprocal social relationships, and of solidarity through a social contract.

The paradigmatic incidences or discontinuities to be examined are:

1. The 'Mother and Child Scheme' — attempted introduction by Dr Noel Browne (1951).
2. The Hepatitis C contaminated Anti-D scandal and subsequent treatment of the infected women (1994-1997).
3. The expansion of the Irish private health care market beyond the statutory monopoly of VHI – Health Insurance Act (1994).
4. The Susie Long case — public patient who died of bowel cancer because her diagnosis was critically delayed (2005-2007).

A Historical Approach to Ireland's Health Care

A number of writers have provided excellent accounts of Irish health care in an empirical sense (Wren 2003; Burke 2010), however, this thesis differs from these accounts in that it seeks to emphasise the way in which Irish health care has become constructed from the discourses surrounding it, and will illuminate the implications of its configuration in the context of a social contract and the gift relationship. Furthermore, this examination will identify the interrelationships between contesting discourses of policy, state, church, charities and people. Distinct hegemonic influences can be seen to have been influential in the creation of Ireland's health care system. The current construction of health care in Ireland is frequently described as being unique and thereby incomparable to neighbouring systems. However, it is the very establishment of this unique situation that warrants deep and systematic examination from a genealogical and discursive Foucauldian perspective.

While Ireland's health arrangements are unique they are also exceptionally unsatisfactory, and yet they go unchallenged and largely accepted as normal despite gross inequities. Read (2009) sees the need for a challenging examination of the process of normalisation in his Foucauldian analysis of neoliberalism stating that: '…the actual process by which it [neoliberalism] became hegemonic, to the point of becoming common sense, is not examined' (p. 25). Similarly, (and in a not unrelated way) the ideology of individualisation and privatisation of health and social needs in Ireland has become dominant. By using genealogy, this research seeks to explore

> '…the historical development of various processes, procedures and apparatuses whereby truth, knowledge and belief are produced and impact on everyday practices' (Björnsdóttir 2002, p.5).

The disruptive potential of a genealogical approach is described by Power (2011), referring to its characteristics as '…precommitted to a kind of critical defamiliarization of the authority of the present via accounts of rupture and discontinuity' (p. 47). Such accounts can be found in the discourse surrounding health and health care in Ireland and, therefore, the process by which the assumptions within these discourses have

become so familiar as to be normalised and accepted, will be revealed in this research.

Challenges

It has been suggested by some that it is notoriously difficult to 'apply' Foucault's approaches to contemporary research, not least because he repeatedly refused to refer to archaeology and genealogy as research 'methods' per-se. Furthermore, interpretation of Foucault's work is often challenging as his thinking is abstract, dense and complex requiring repeated reading (Scheurich & McKenzie 2005). There are, therefore, many traps that a Foucauldian approach might seek to avoid. The temptation to explain or provide causality would appear to be the primary risk for a researcher new to Foucault's methods and more used to empirical research. This approach should not seek to explicate contingencies so much as to explore the historical development of the related discourses and practices. Kendall & Wickham (1999) advise the Foucauldian scholar to 'break the habit' of looking for causes and instead to consider contingent relationships.

Walker (2002) also outlines the challenge of using Foucault's concepts in her genealogy of equality and she identifies the '…risk of oversimplifying his approach and of selecting one part of his work to the neglect of other aspects' (p.17). However, evidence from the literature would suggest that his genealogy has proven to be more popular among scholars as an adopted approach than his archaeology, despite the fact that a more substantial portion of his writing referred to an archaeological approach than to a genealogical method. Scheurich & McKenzie (2005) suggest that genealogy appeals more to scholars as it 'is more like a set of critical tools that can be used', whereas the archaeological method:

> 'is dependent on a highly structured, highly interrelated set of constructs, all of which need to be deployed together to actually do an archaeology' (p.857).

In his lecture series at the College de France, published together as 'Society must be defended' (2003), Foucault makes the clearest, yet still complex, statement that

explains genealogy and relates its method to one that explores hierarchies of knowledge and subjugation:

> '…genealogy is, then, a sort of attempt to desubjugate historical knowledges, to set them free, or in other words to enable them to oppose and struggle against the coercion of a unitary, formal, and scientific theoretical discourse. The project of these disorderly and tattered genealogies is to reactivate local knowledges […] against the scientific hierarchicalization of knowledge and its intrinsic power-effects. To put it in a nutshell: Archaeology is the method specific to the analysis of local discursivities, and genealogy is the tactic which, once it has described these local discursivities, brings into play the desubjugated knowledges that have been released from them (Foucault 2003, p.10).

Conclusion

The adoption of a genealogical approach to this research provides a novel method through which an examination of the historical origins of Irish health care can be performed. This chapter has demonstrated that a historical approach is necessary in light of the research questions and that, specifically, a genealogical method is most appropriate. The manner in which genealogy seeks to challenge that which has been taken for granted, and to question long held assumptions that have been repeatedly represented as fact in lasting systems of discourse, strengthens the selection of this approach.

Contemporary public perceptions and conceptions of health are not without origin. It is hypothesised in this thesis that the current tolerance of, or acquiescence to, an unjust and unequal health care system has its roots in the archive of neoliberal discourse and other influential discourses of power that have sought to individualise issues surrounding health in Ireland. Particular moments of critical importance to subsequent perceptions of health care can be used as effective exemplars or critical junctures, moments when a critical perspective might have emerged and when opposing discourses can be seen to exercise power in crucial relations.

The wide range of literature drawn upon in this chapter serves to demonstrate the substantial suitability of the genealogical approach for research of contemporary problems that relate to issues of power, knowledge, discourse and subjectivity.

Chapter 6: The Genealogies

Introduction

What follows in this chapter is the narration of a series of key transformative watershed moments in Irish health care. These moments could be described as 'ruptures', as understood by a genealogical Foucauldian approach to historical examination. Each event represents a discontinuity in the history of Ireland's health care system, and it is as a result of the layering of the attendant discourses that Ireland has the health care system that it has today. The nature in which Irish people were considered and conceptualised by those in power (the church, the medical profession, the government, the policy makers) has, it is hypothesised, contributed significantly to the public's understanding of what it is that a health service should be, what it is that Irish people are entitled to, the actuality of a social contract between citizen and state and, ultimately, what value is placed on health and on a good quality of life in Ireland.

The intention here is not dissimilar to that of Bennett (1995) who stated that the purpose in his genealogy of the museum was to provide an account of its

> '…formation and early development that will help to illuminate the co-ordinates within which questions of museum policies and politics have been, and continue to be, posed'(p.5).

Bennett's analogy of co-ordinates suggest a degree of limitation or perhaps a restricted range of thoughts within which policies are formulated. Similarly, this chapter shall illuminate the path by which Ireland's health care system, and indeed the general acceptance of its very nature, has been influenced by the discursive regimes surrounding these events that represent discontinuities and transformations of the previously known status quo.

Bjornsdottir (2002) promotes the use of a genealogical approach to a study of this nature as it '…studies the conditions that lead to the emergence of particular discourses and practices' (p.5). Health and health care are subjects that are uniquely universal in their application and relevance to all persons and to all eras. It relates

ultimately to our human existence and our lives. In an ideal sense then, it should be interpreted as a core human value understood in a common manner. However, it is in fact interpreted in an evolving sense and the evolution of these understandings can, it is suggested, be seen to have been influenced by historical circumstances or, more specifically, by the competing discourses related to these circumstances. Foucault refers to these circumstances as:

> '…not a decision, a treaty, a reign, or a battle, but the reversal of a relationship of forces, the usurpation of power, the appropriation of a vocabulary turned against those who had once used it..' (Foucault 1984, p.88).

In many ways, the nomenclature of a social contract, in which a state provides for the citizens' needs, has been appropriated, in the manner that Foucault suggests, by market forces. Privately run health care provision, for example, now occupies the place of any universal provision with payments of insurance premia at its core. This appropriation and occupation is evidenced by the language of advertising, of policy makers, of media coverage and by the perceptions of health care recipients and their actions. An excellent example of this is the use of the terms 'community rating' and 'intergenerational solidarity' that are commonly used in reference to private health insurance (McDonnell & O'Donovan 2009). The consumer purchasing a policy is assured that their actions are contributing to a sense of solidarity between their generation and that of the older one, who should not be required to pay a higher premium in their old age. Instead of fostering a true sense of community, the health insurance market fosters a determined culture of individualism which is very far from the communal culture suggested by the term 'community rating'. Furthermore, politicians can be seen to have taken over the language of universality in their vociferous promises in Ireland, for example, of 'universal health insurance', a term that merges what some might regard as disparate concepts. Baert(1998) describes the role of the genealogist in identifying such a process of appropriation, which he suggests occurs through the allocation of new meanings due to power struggles or contingency. With the appropriation of such discourse and vocabulary comes the usurpation of their related power.

The examination of the historical events that follows will demonstrate the long established loci of control in Ireland, as well as, what can be now seen as, significant power shifts. Most significantly the arguments, understandings and perceptions of issues surrounding health and health care in Ireland will be seen to have evolved and erupted as a consequence of the layering of each of these discontinuities and their discourses. This genealogical approach is appropriate here as it:

> '…facilitates a recognition of social contingence through continuities and discontinuities, while acknowledging the importance of identifying points of origin and rupture via an attentive analysis of the mythical and symbolic language through which they are formulated and narrated' (Salvatore 2007, p.26)

It is worth considering here exactly why these particular events were chosen. Irish health care is bestrewn with significant moments and historical developments that have had prolonged influence on policy makers and their decisions. What is particular about these four genealogies is their effectiveness as exemplary demonstrations of the subtle, yet significant, impact on society when the social contract is broken, when the gift relationship is corrupted and when solidarity is eroded.

The genealogical treatment given to each of these ruptures in this chapter clarifies and exemplifies the consequences when the social contract is violated and when the gift relationship is neglected. The concept of solidarity, for example, is not seen to be consistently modelled by those policy makers and holders of power that are involved in these cases. To identify instances of power within the relevant discourses, the four cases or genealogies were selected. Many others could be used and new rupturing moments continue to emerge that would also provide rich evidence of transformative layering of discourse. However, just these four were selected as they enable an effective history of Irish health care. They span sufficient time periods as to be indicative of the evolution of relevant developments historically, economically and socially. Furthermore, they relate to different kinds of moments, some very public

and involving many people, some more intimately relating to individual actors, and others relating to policy and legislative developments. Together the cases enable the broad perspective that this thesis requires and they provide useful and illustrative exemplars that reveal powerful actors, reveal the potency of market forces and make publicly visible many private troubles.

Dr Noel Browne's Mother & Child Scheme

The attempted implementation of the Mother and Child Scheme by Dr Noel Browne in the early 1950s was extremely significant and can be seen now to have been socially, politically and perhaps theocratically pivotal in its failure. As a child Noel Browne had experienced significant personal loss and illness and, as a consequence of rampant TB in Ireland, saw first hand the significance that personal wealth and privilege had on one's health and indeed on one's prospects for survival. Through acts of altruism and philanthropy he was lucky enough to survive, to be educated and to go on to study medicine in Trinity College Dublin. He was clearly influenced by the efforts made by English doctors to treat his own TB related conditions in the 1940s:

> 'I still marvel at the generosity of a society which, in the middle of a war of such ferocity, could have turned aside to concern itself with saving the life of an unimportant outsider…' (Browne 1986, p.76).

Here, it could be said, he was once again witness to altruism and to the gift relation in its purist form. He was given the gift of a continued life. His consequent deeply held beliefs in the unfairness of health disparities led him to strive to create policy and legislation that would provide free health care for mothers and their children at a time when infant mortality rates in Ireland were one of the highest in Europe. He battled to introduce such policy at a time when Ireland's public health status had been seen to be shamefully poor and state efforts to improve the situation sat in stark contrast to the development of the welfare state in neighbouring Britain (McKee 1986). Having been the beneficiary of what could be described as a social contract in the form of the British National Health Service, Browne sought to convince the relevant powers in Ireland of the merit of an Irish equivalent.

Noel Browne's efforts to establish the Mother and Child scheme came up against stiff opposition and, more crucially, extremely powerful opposition. The Catholic hierarchy, led by Archbishop John Charles McQuaid made explicit their objections to the Mother and Child Scheme. They argued that it amounted to a form of socialised medicine with a risk of Irish Catholic women being exposed to gynaecological health

education that ran counter to catholic teachings. The Bishops and Archbishops of Ireland set out their objections when they wrote directly to the Taoiseach John A. Costello:

> 'The powers taken by the State in the proposed Mother and Child health service are in direct opposition to the rights of the family and of the individual and are liable to very great abuse. Their character is such that no assurance that they would be used in moderation could justify their enactment. If adopted they would constitute a ready-made instrument for totalitarian aggression' (Browne, 1951 p.8).

Their protests against the scheme also cited a concern for the confidentiality of the doctor-patient relationship as well as a claim that by providing for a minority of children in want of care, the scheme would remove the rights of parents of the majority of children already well looked after. In his memoirs Dr Browne surmises that the Catholic bishops may have been offended by having to even deal with a minister who had trained in the Protestant medical school of TCD at a time when '…annually from the pulpit Archbishop McQuaid forbade Catholics to attend TCD under "pain of mortal sin"' (Browne 1986, p.142). But the influence of the Bishop went far beyond his own church. Health care in Ireland at that time was largely delivered by religious orders and, by implication, the training of health professionals was similarly under direct religious influence. Government policy too can also now be seen to have been lacking democratic autonomy. No better illustration of this intertwined church and state exists than an excerpt from a telegram sent to Pope Pius XII from the Taoiseach of the new coalition government of 1947:

> 'On the occasion of our assumption of office and of the first Cabinet meeting, my colleagues and myself desire to repose at the feet of your Holiness the assurance of our filial loyalty and our devotion to your August Person, as well as our firm resolve to be guided in all our work by the teaching of Christ, and to strive for the attainment of a social order based on Christian principles' (Keane 2006, p.16)

Keane identifies this as 'an excellent example of the deference the inter-party government demonstrated to the Catholic hierarchy' (Keane 2006, p.16). Such discourse of deference is laid bare by Bowman (1999) who describes a series of similarly fawning handwritten letters sent to the archbishop of Dublin by Clann na Poblachta party leader Sean MacBride as the political equivalent of blank cheques. Through this dialogue the actual positions of power were delineated. In one response the bishop assured MacBride that he would not 'fail to take advantage of your generous suggestion that you are at my disposal for any matters in which you could assist..' (Bowman, 1999 p.10). Such assurances, although hardly necessary, fortified the confidence of the bishop in his subsequent battle with Noel Browne over the Mother and Child scheme. Indeed he boasted of his victory on the matter including the resignation of Browne in a letter to the Papal Nuncio claiming it to have been the most important event in Irish history since Catholic emancipation in 1829 (Cooney, 1999).

> 'The ideological reality of the 1950s was that Browne, a democratically elected politician with a social vision, was a pawn in McQuaid's Cold War struggle against Communism and its milder but no less insidious form of "socialised medicine", which had spread to Britain and Northern Ireland in the guise of the Welfare State' (Cooney 1999, p.252).

This was not the first time the catholic hierarchy had interfered overtly in state policies; in 1947 the then government received a letter of protest from the hierarchy objecting to the new Health Act which was to provide the foundations for the Mother and Child scheme. Barrington (1987) notes that this was the first time the church had formally protested to government on a specific piece of legislation and she points out that they did not even need to construct their argument but '…it was sufficient to state the danger as they saw it and to make their opinions known to the government' (p.186). The dispensability of explanation and clarification in the bishops' protest is indicative of their presumption of control and authority over the government ministers and other policy makers. This demonstrates powerfully the manner in which diktats

from the church were expected to be accepted without recourse to rational or critical debate. Judgements of moral or theological matters did not necessitate persuasive explanations.

However, it would be naive to assume that the only powerful actor exerting influence to scupper the Mother and Child scheme was that of the Catholic Church. Lee, for example, (1989) cautions readers of history of an 'over-simplification to present the Mother and Child Scheme … as a straight conflict between church and state' (p.318). The medical profession and particularly consultants were extremely disgruntled at the prospect of the scheme, particularly the absence of a means test. Fallon (2004) suggests in fact that the church's objections to the scheme probably came about as result of '…considerable promptings and lobbying by upper-class, well-to-do Irish doctors who feared encroaching welfare statism, as in Britain' (p.34). To many observers and commentators the objections of the medical profession to an effort to implement a scheme with such a high level of public good is hard to fathom. There is perhaps more veracity to be found in considering the objections of the medics in terms of power than there is in terms of greed. The Irish Medical Association (IMA) were already aggrieved as they considered that they had not been properly consulted on the Public Health Bill (1945) by Dr Con Ward, the Parliamentary Secretary of what was then the Department of Local Government and Public Health. Indeed a former president of the IMA, Dr Patrick McCarvill, went so far as to write to De Valera in 1946 making allegations about Ward's conduct as a businessman and as a doctor. A tribunal subsequently cleared him of all but one charge that related to tax returns on his business and he was forced to resign (Wren, 2003). With this, their first political scalp, the medics were fortified and truly aware of their power as an organised group. Ward's minister, Mr MacEntee remained committed to health reform, however, and at an address to the IMA later that year he expounded to the assembled doctors the affliction of patients without the means to access medical care. That a minister should need to moralise to a medical profession is paradoxical but is, at the same time, a useful measure of the social thinking at the time and of the positioning of the medical profession in the political and societal hierarchy.

By 1947 the Health Bill had been amended considerably under the office of the first Minister for Health, Dr James Ryan and many controversial elements had been removed. Despite this, it was still seen as a threat to the private practices of the medical profession {Ferriter:2004vt}, who now enjoyed the support of Fine Gael deputies Dillon and Mulcahy who also objected to the scheme. A group of doctors based in Limerick, led by a Dr James McPolin, while lobbying the IMA also sought the involvement of the church hierarchy:

> 'Dr McPolin took his case to the Bishop of Limerick, Dr Patrick O'Neill, seeking his opinion as a churchman on whether the obligation in the Act on doctors to disclose records of their patients constituted a menace to professional secrecy and whether compulsory medical inspection was a threat to parents' rights. The bishop answered both questions in the affirmative' (Barrington 1987, p.186).

So here it can be seen that the doctors and the religious hierarchy were mounting a collaborative attack on what was to become the Mother and Child scheme many years before Noel Browne took office in February 1948. This collusion explains why the objections of the Hierarchy of the church and those of the doctors' representative organisations featured uncanny similarities. Evidence from the papers of Bishop John Charles McQuaid indicates that he had been provided with minutes of IMA meetings with Browne. Furthermore, as Browne was seen to be failing to negotiate with sufficient delicacy with the bishops and the doctors, the Taoiseach, John A. Costello, and others in cabinet had taken over and had begun to engage directly in negotiations with the IMA. So, in effect, Browne had to contend with actions, objections and protests from numerous corners, even within his own party and cabinet.

Ultimately, Browne's plans were thwarted through an unfortunate combination of his own blunt doggedness, the interference of the church who collaborated in supporting the protests of the medics and the collusion of his own Taoiseach. Communications and clarifications intended for Archbishop McQuaid, for example, had not been dispatched, others had been edited by Costello before being delayed significantly

and indeed the Taoiseach and McQuaid had together drafted cabinet communications (Cooney 1999). The Bishops formally objected to the scheme through a letter, which was read at the cabinet table. In his pleas to fellow ministers to support the scheme elected representatives declared their faith as Catholics as taking priority over policy decisions and expressed outrage at having to even declare this status. Noel Browne tendered his resignation in April 1951 however the fall-out continued long afterwards in the form of Dáil statements, newspaper articles and significantly, the publication in the Irish Times by Browne of all of his communications with the Hierarchy. Here the private discourse of communications between those in power (politicians, bishops, doctors) became visible. What happened thereafter is of real significance for this thesis. The Irish people saw clearly now the direct and deliberative hand of the church in their governance. As the editorial in The Irish Times on April 12th 1951 stated 'The most serious revelation, however, is that the Roman Catholic Church would seem to be the effective Government of this country' (Smyllie 1951).

Commentators have since suggested that this was the moment after which the Irish peoples' views of the church, and indeed its relation with the state, were changed forever:

> '…scales fell from many eyes which previously would never have looked askance at a priest or bishop. […] In the interests of some dogmatic or theological obsession, which made very little sense to anybody outside its ranks, it had acted against the interests of public health and the poorer classes. […] From then on, the power and prestige of the Catholic hierarchy in Ireland began to wither slowly… (Fallon 2004, p.35)

Barrington (1987) contends that the anger of the people with the hierarchy's interference surprised the church authorities which may have resulted in more considered actions on their part in socio-political issues in the future. Heretofore, the social contract with which the Irish citizen was most familiar was one that involved the Roman Catholic Church. Now that the hierarchy of this church had been seen to

have dismissed the wellbeing of a vulnerable sector of Irish society, that contract was now corrupted. By seeking to secure and maintain their powerful influence in Irish politics, the church had broken a fair and just social contract that many Irish Catholics believed they had entered into. How now could they continue to respect and honour a party to a contract that had been dismantled so callously in such a public manner? As the maternal and infant death rate continued to be witnessed by underprivileged Irish families, they saw also a failure of their caring church to act in an enabling way towards social and health policy that was to have been the beginning of an accessible and equitable health care system for all.

Similarly, the actions of some representatives of the medical profession demonstrated a failure to identify their role in the unique relationship of doctor and patient. Instead of a relationship based upon a gift of care or altruism, the medical profession was revealed instead to be closer to a collection of businessmen engaging in financial transactions in a purely commercial relationship instead of a gift relationship. Browne had made no secret of his distaste for the coexistence of medicine and fees for service (Barrington 1987), having been made acutely aware earlier in his life of the core position of medical care in the gift relationship as experienced in the National Health Service. The objections of the IMA and the consultants to the Mother and Child scheme laid bare to their patients their fear of becoming state-salaried doctors in a socialised health system without means testing which they feared would have 'obliterated a whole section of private practice for doctors' (Kennedy 2001, p.189). Their objections to this were seen all the more cynically as they were couched in terms of the same moral objections voiced by the Catholic hierarchy. The financial implications for the private practice of general practitioners and some consultants was clearly the core issue and ultimately it was this that forever tarnished public perception of the values held by the doctors of Ireland as they engaged in their professional relationships. Furthermore, their objections succeeded in turning the Mother and Child controversy into a class related issue with dispensary doctors warning that the sensitivities of their well-to-do patients would be offended at the notion of 'sitting alongside tinkers' wives and others of similar type' (Barrington 1987, p.206). The financial interests of the doctor could not have been further from the principled approach to health care that Browne advocated and indeed that others had assumed was the driver of medical practice. A

letter writer to the Irish Times, for example, in the aftermath of Browne's retirement identifies him as standing out because he '…upheld the principles and ideals which he put before the public…' (Ffrench-O'Carroll 1951)

What the Mother and Child scheme controversy achieved was a revelation of the powerful actors in Irish politics and society as well as a demonstration of the absence of pure principles in the motivations of those in such positions of power. Foucault refers to power not in the overt discourse of policy and public pronouncements, so much as the insidious inherent discourses of everyday life. The church and the medical profession erased any doubt as to their power in the lives and wellbeing of Irish people and succeeded in promoting and validating an Irish society that lacked any solidaristic intentions towards the underprivileged and vulnerable. In hindsight, it is possible to consider this controversy as the very beginning of the end of Catholic domination in Ireland's State affairs and perhaps some degree of public realisation of the need for effective separation of Church and State. Some seeds had been sown that would grow to 'challenge the enduring power and influence of the Church' (Bacik, 2004).

Garvin (2005) suggests that the weakening of the power of the church 'resulted in part from an elite perception that this intellectual conformism and authoritarianism had failed the country and even endangered its future' (p.14). The growth of this perception continues at a slow but deliberate pace. In 2009 Senator Bacik remarked:

> 'Even now, the Catholic Church continues to act as a sort of "shadow welfare state", supplanting the State's role in many ways. It also continues to hold vast tracts of valuable land; and to wield great social and political power' (p.7).

However, for 1950s Ireland a change in attitude and a questioning of Catholic hegemony was a significant transformative move. Fuller (2005) remarks that the public challenges to the church in the aftermath of the Mother and Child controversy 'marked a crossroads in Irish Catholic culture, and the widening of a sub-culture of dissent which generally speaking had only involved the intelligentsia or literati up to that time' (p. 47). It could be seen, therefore, that the voices of those questioning the dominant role of the Church in state matters were no longer lone voices of what

could have been regarded as protected extremists, but were increasingly the voices of the citizenry. However these questioning voices were to have a long and bitter struggle to be heard and to gain significant ground in a country whose deference to Catholic hierarchy was ingrained into the genetic makeup of its people. Consequently, the Catholic Church continued to wield significant power over State issues and related social strategies well into the 1990s and '…its influence was particularly forceful and successful in its efforts to resist social reform in the domain where it saw itself as holding the moral monopoly…'(p.2). The ground gained by those fighting Catholic dominance over social issues in the 1990s was likely primed by the public's interpretations of the discourse surrounding the events that had gone before, including the public debacle that followed the abandonment of Noel Browne's ill-fated Mother and Child Scheme. Such discourses revealed the role of the powerful church in imposing discipline and control over Irish citizens, as the opposing forces of theocracy and democracy struggled for coexistence. This moment served, therefore, as the first of many 'jolts and surprises of history', as Foucault refers, that commenced the reversal of the relationship of forces in Irish social life and thus the corruption of Ireland's social contract.

Contaminated Blood

In February 1994 representatives of the Blood Transfusion Service Board (BTSB) came to the Department of Health to alert the Minister for Health, Brendan Howlin, of a potential risk to women in Ireland who had received the Anti-D blood product. They had become aware, they said, of the possibility that the product may have been contaminated by a donor with Hepatitis C. The minister instigated an appropriately prompt response and within days all women who had given birth, and had therefore been given the Anti-D injection within the relevant period, were called to be screened. A change of government by November that year resulted in another minister inheriting the problem and managing the consequences, sometimes rather poorly. While the government eventually offered a 'no-fault' tribunal and compensation, the women and their families endured a long battle in which they sought answers and explanations. What followed in the subsequent years was a series of revelations about the BTSB, principally through the Finlay and Lindsay Inquiries, of poor surveillance management, dismissal of risks, an underfunded service that was unable to practice safely due to severe cutbacks and ultimately a callous disregard for the well-being of those receiving blood products. The gradual uncovering of these events and of the attitudes of those in positions of power succeeded in forming a further rupture in the history of Irish health and social care, specifically a rupture that went to the very heart of the relationship between the state and the citizen.

The cohort of victims of the failings of the BTSB and its officials grew to include not just women who received the Anti-D product, but also unfortunate Haemophilia sufferers who had received clotting agents found to be derived from HIV positive donors. They had already been granted a modest compensation package by a previous government back in 1991, however, they saw now an opportunity to seek true answers to their questions about how this could have been allowed to happen. They sought the terms of reference of the Finlay inquiry to be expanded to include their cases. While they were allowed some representation they ultimately withdrew and, with many of their members dying of AIDS related diseases, they successfully campaigned for their own tribunal of inquiry, which was finally set up in 1999 by Judge Alison Lindsay (Wren 2003). The Lindsay tribunal called 150 witnesses within

200 days of sittings and produced what some have criticised as a report written largely in the passive voice. O'Toole (2002) wrote in the Irish Times:

> 'Both they [the victims] and the rest of us who need to know we have a functioning State had a right to expect that an inquiry into such hideous failures would be clear and forthright. What we've actually got is an exquisite exercise in the uses of the passive voice' (O'Toole 2002, p.14)

Here O'Toole narrates public concerns about accountability and a failure to attribute culpability to an arm of the state that failed to maintain its obligations within a social contract.

Mrs Brigid McCole

In the 1990s victims of the unsafe practices of the BTSB, effectively an arm of the state, organised into an effective and solidaristic pressure group known as Positive Action. They fought to have the truth revealed and to have those responsible identified, as well as to gain compensation for their damages. One woman in particular, Brigid McCole, stood out, as she agreed to take her case to the High Court despite the fact that she was extremely unwell. In 1996 she sought to take her case against the state, the BTSB, against the attorney general and against the National Drugs Advisory Board (NDAB). That a citizen harmed by poor practices and underfunding was forced to take a case to the courts to seek answers and redress was a public relations disaster for the government whose legal advice was that the BTSB was liable but the state was not directly so. As preparations for the case dragged on (the BTSB requested more time to gather data) and Brigid McCole became weaker, and as the minister for health came under increasing public pressure, the legal teams representing the state and the BTSB continued to hound the dying woman. Having refused her the right to anonymity on the grounds of constitutionality, (a cynical move that was seen as an attempted deterrent to other potential victims) she was still receiving communications from the BTSB's legal team only days before she died. When she finally received a letter from the BTSB conceding liability it was found also to contain thinly veiled threats that if she

proceeded with the case and were to be unsuccessful, that the BTSB would make an '…application to the court against your client for all costs relating to the claim for such damages and for an order setting off any costs to which your client might otherwise be entitled' (O'Toole 2001). The Minister for Health, Mr Michael Noonan, it emerged in the later Finlay Tribunal report, had seen this letter before it was sent. However, this was not the first time that intimidating communications were received in relation to this scandal. Irish Times journalist Fintan O'Toole reported that in July 1995:

> '…the Chief State Solicitor, acting for Michael Noonan, warned Positive Action, the umbrella group for the victims, that unless they went quietly to the compensation tribunal they would face "uncertainties, delays, stresses, confrontation and costs". Any cases the victims might take would be defended by the State, "if necessary to the Supreme Court"' (O'Toole 2001).

A week after Mrs McCole's death Minister Noonan conceded to demands for a full judicial inquiry appointing Judge Tom Finlay to oversee the tribunal (Wren 2003). However, a further insult to the women involved in this case was experienced when the Minister made remarks in the Dáil to the effect that the legal team of Positive Action ought to have chosen another claimant, other than Mrs McCole, to take their test case to the High Court. Having given the house a full description of the case and having pointed out the advantages of taking the tribunal route over the adversarial court route, he said: 'Could her solicitors not, in selecting a test case from the hundreds of hepatitis C cases on their books, have selected a plaintiff in a better condition to sustain the stress of a High Court case?' (Oireachtas 1996). Although probably not intended as such, this remark was taken to be scornful and disrespectful and it opened Noonan up to multiple criticisms from opposition members in the house at the time, from Positive Action members and from the media. He withdrew the remark and apologised profusely the next day for causing any offence to Mrs McCole's family (Kelly & O'Regan 1996), but many felt the damage to his political character had been done and that it was a major cause of his subsequent electoral defeat (Wren 2003; Power 2010; McGee 2010). A further

example of disrespect towards the victims of blood contamination occurred in 1986 when the medical director of the National Haemophilia Treatment Centre, Prof Ian Temperley presented a paper at a medical conference in University College Dublin in which he demonstrated his awareness that 5 haemophiliac patients he was treating were HIV positive; information that the patients themselves had not yet been told. A high ranking member of the Irish Haemophiliac society who was attending the conference was shocked to see initials of patients that he recognised projected on a slide during Temperley's presentation (RTE 2001). That such sensitive and urgent information was shared with fellow professionals before it was shared with the patients themselves is demonstrative of an astounding level of arrogance.

In terms of holding those responsible to account, an attempt was made in later years to take criminal proceedings against two BTSB staff members, Ms Cecily Cunningham and Mr Terry Walsh, who had been alerted to the risk of contamination by researchers in a London hospital in 1991, yet had failed to act on the information. The case was ultimately dropped by the DPP in the case of Ms Cunningham, yet she remained liable for the legal costs, while Mr Walsh had died in the interim.

A Broken Contract

The whole 'blood scandal', as it became known, ultimately resulted in the infection of some 1600 people with Hepatitis C or with HIV. Ireland was not the only country struggling to cope with the fall-out of such contamination and transmission of infections. Similar difficulties had to be dealt with in Canada, China, Denmark, Italy, the UK and in France where legal proceedings resulted in some officials receiving custodial sentences (Orsini 2002; Power 2010). However, what can be seen in examining the discourse surrounding the Irish case is that issues of trust, veracity and accountability feature very strongly. Victims and their families experienced feelings of neglect and hurt by a health system that ought to have enhanced their lives. The faith of the Irish people in the blood donation and transfusion system, as well as in the health system and its policy makers, was severely shaken in what has been described as the worst public health scandal in the history of the state (Taylor & Power 2010). Such faith, truth and trust are vital components in a social contract between citizen and state, and in their absence a vacuum is established where

distrust, cynicism and individualism take hold. Women and haemophiliacs who had allowed their bodies to be infused with a contaminated substance, directly into their bloodstream, now feared that they had been wrong to place their trust in those overseeing the process. To make matters worse, as the truth began to emerge it could be seen that much could have been done to prevent the crisis. The BTSB had first been made aware in 1976 of the fact that a donor whose blood had contributed to the production of Anti-D had been diagnosed with infective hepatitis. A year later, when a number of recipients of this anti-D became infected with hepatitis the BTSB still took no action (Farrell 2006). Warnings were ignored and attempts to cover up mistakes were made. When concluding in relation to why preventative actions were not taken by BTSB staff, the Finlay report concluded that they seemed to be reluctant to accept the mistakes they had made and endeavoured to avoid the inevitable fallout that they rightly feared. The tribunal report, directly responding to questions posed by the family of Brigid McCole, stated that BTSB staff '…were particularly anxious not to admit of any breakdown or failure…' (Finlay 1997, p.137) and:

> '…a blank refusal to contemplate even the consequences of what then clearly appeared to have been done wrongly by the BTSB in 1977, and a sort of vague and irresponsible hope that the problem might go away' (p.138).

There was, it would seem, a reluctance to admit wrongdoing and thereby a preference to side with mistruths. The campaigners and victims involved in Positive Action were resolute in their efforts to seek answers to why this happened to them and to their families. Over and over again in press releases and newspaper articles they repeated the mantra that they just wanted 'the truth'. The state, however, were keen to moderate the degree of truth telling and preferred to usher the victims towards a no-fault tribunal. Hence, the bravery of Brigid McCole was so noteworthy. Despite her failing health, she persisted with her High Court bid confident that further revelations and documents would come to light, as indeed they did. The organisations and individuals in the BTSB, the NDAB and in the Department of Health were not seen to have voluntarily provided truthfulness until they were

compelled to do so. This reluctance to provide the truth can be seen to be paradoxical when considered within the modern domain of clinical realism, with a persistent seeking of truth, in which many of these scientific individuals had trained and practised.

The absence of adequate levels of truthfulness was, and remains to be, fatal to a trusting and faithful relationship between citizen and state. Barrett et al(2007), referring to the work of Taylor-Gooby (2006) on public trust in institutions concludes that:

> '…trust in institutions involves two factors. First, a cognitive factor, whereby rational judgements are made about the trustworthiness of the institutions. Second, an affective factor which involves feeling that the organisation is working for you and feeling respected by it' (p.384).

In addition to issues of trust and honesty, this genealogy also points to the crucial values of accountability and culpability in particular when examined in the context of the welfare state and its actions relating to vulnerable dependents. O'Toole (2002) for example alerts Irish Times readers to this failure to accept responsibility in his identification of the conspicuous overuse of the passive voice in the Lindsay report . He is also unstinting in his clear depiction of the BTSB's neglect of the recipients of blood products:

> 'The reality, though, is that the Irish system made nearly all the wrong decisions, ignored new scientific developments, didn't bother to recall products that were known to be potentially lethal, and treated the victims of these failures with mind-numbing callousness' (p.14).

An attempt to change image and shift away from its regretful history is evident in 2000 when the BTSB was renamed the Irish Blood Transfusion Service (IBTS). However, the same core issues remain in 2002 when the IBTS refers to issues of accountability in the minutes of their Board meeting of April 2002, and interestingly

they are in a position to discuss the report a full 5 months before the report is made public in September 2002 (IBTS 2002). When presenting the findings of the Lindsay tribunal to the board, the CEO refers to a number of 'lessons to be learnt' from the report. Instead of lessons that might place the safety of recipients as central to their mission, the minutes instead record that Mr Hynes refers to the 'trauma' of the inquiry for the IBTS and how this might affect decision-making, and he also bemoans the presence of an adversarial legal system that impedes the swift settlement of medical negligence cases. Still, even at this point after two tribunals of inquiry, much illness, heartache and death, this board does not place patient safety as central to its continuing mission. In their September board meeting, after the publication of the Lindsay report, when one might expect to see this as perhaps the single item on an agenda, the minutes of the board of the IBTS instead record in a few lines that the now Acting CEO (the former CEO appears to have left in June 2002) notes the release of the Lindsay report and states simply: 'that in-depth analysis of the recommendations and conclusions would be required so as to respond expeditiously and appropriately to all recommendations'.

Those infected with Hepatitis and HIV by blood products had made cognitive judgements on the trustworthiness of the relevant authorities and the providers of their service; these judgements, it transpires, were misplaced. The affective notions of being cared for and respected by the organisations of the state were wounded, more so by the aftermath and treatment of the victims than by the initial failures that led to their infections. Barrett (2007) points out that interpretation of risks by the public with regard to health, tend to be focused on notions of an ability to trust individuals, than on generic feelings of confidence in a larger system or institution. He suggests, however, that this alters when it comes to issues of blood whereby individuals are more concerned with confidence in an effective system than with interpersonal notions of trust. Barrett's suggestions seems to be at odds though with Titmuss's conceptualisation of the gift relationship as epitomised by blood donation. Developing the work of Mauss, who interpreted the notion of societal systems of exchange as on-going, unfolding relations of reciprocity, Titmuss identifies the altruistic offering of one's blood as an instantiation of the ancient tradition of a gift exchange (Titmuss & Oakley 1972). He believed the system of voluntary blood donation to be an encouraging factor in the maintenance of an altruistic society.

Such an altruistic approach focuses on the individual as opposed to a whole health system, as suggested by Barrett (2007); the donor is able to empathise with giving to a 'somebody' not merely to a system of blood processing. The failures of the Irish blood transfusion services in the past may have deemphasised the relevance of confidence in the system with donors and recipients more reassured by notions of the individuals involved in donating and in need of donations. At the time that Titmuss wrote of the gift of blood though, there had not been the same degree of public questioning of the ability of the health services of the time to deal safely with blood and its recipients (Busby 2010). Much has changed since Titmuss's day in terms of public perceptions of health and health services, and there have been, in Ireland for certain, numerous tribunals and discoveries of mismanagement of many state organisations. Levels of trust in public bodies are understandably diminishing.

As well as trust and truthfulness, the notion of respect is another vital component in any social contract. By his dismissive remarks in the Dáil, Minister Noonan accidentally revealed the true feelings of his government towards these women. Ironically, this may have been one of the few instances of truth telling witnessed in this debacle. The truth it showed, however, was not one that was palatable to many of the women and their families. This ill-advised discourse, and other examples that were to come to light in the process of the Finlay and Lindsay tribunals, were demonstrative of the disdain with which these victims of state errors were really perceived. Their visibility coupled with their persistent demands for the truth were an inconvenient reminder of the failure of the state to adequately fund and oversee a vital component of the health system, in other words, the state's failure to keep to their side of the social contract. The fact that their failures resulted in a corruption of the ultimate example of the gift relationship, the giving of blood, makes this rupture in the history of Irish health care a particularly significant one.

The victims of blood contamination were patently in the care of the state, but instead of receiving care they were the recipients of a contaminated gift. From this moment the state's actions sought to move them outside of its sphere of responsibility and, in the case of Brigid McCole, sought to instead transform the citizen into an enemy of the state. This was the transformative moment that succeeded once again in reversing the relationship of forces. The BTSB as an apparatus of the state acted

with maleficence and employed punitive instead of caring forces. As the BTSB fell prey to market forces and sought to provide their service within a global market domain they enabled the contamination of the gift and corrupted the altruistic gestures of blood donors everywhere. This contamination was detrimental in its spread through the bloodstream of the individuals and also that of Irish society. Forever, the altruistic gesture of the blood donor would be poisoned by the influence of the market and the gift would be perceived as potentially corrupt.

A genealogical examination in the tradition of Foucault utilises skills of suspicion in '…uncovering the unsavoury provenance of ostensibly noble enterprises' (Flynn 2003, p.37). For this reason this tradition is well suited to the examination of the blood transfusion service in this case as it reveals that its original primary role in provision of a service to the citizens of the state, became unsavoury as it engaged instead in the market. This further transformation created a 'double jeopardy' situation for the citizens who received the contaminated gift and were then neglected by the state who sought, rather than to care for them in their injured circumstances, but instead to subsequently punish them. In many ways the BTSB, the State and the Citizen all fell victim to the massive potency of market forces.

The Health Insurance Market in Ireland

Another significant transformative moment can be identified when examining the development of the health insurance market in Ireland. Health care in Ireland has a long history of being one that is a relatively unique mix of public and private provisions. The Voluntary Health Insurance Board (VHI) was established in 1957 as a government-owned corporation and, up until 1996, was the only health insurance provider in the state. Since the establishment of the VHI there has always been a strong appetite for private health insurance in Ireland, but this can be seen to have been induced by the nature of health provision policies. The VHI was intended initially to provide in-hospital cover for the top 15% earners in the country who were not entitled to access the public system (Harmon & Nolan 2001) however by the 1970s they too were able to access public hospitals but would still need to pay consultant fees. The 1980s and 1990s saw a steady rise in the percentage of the population covered privately and by 2005 47.6% of the population had private health insurance with this proportion peaking at just under 2.3million in 2008 (The Health Insurance Authority 2012).

However, numerous national and international circumstances and policy developments have led to an evolving perception of the value and need for private health insurance over the last 50 years in Ireland. Harmon and Nolan (2001) indicate that the insured tend to cite swifter access to health care and a fear of health care bills as the primary rationale for purchasing private health insurance. Many also, often erroneously, assume a better quality of care will be delivered to them as a private patient than that which they would receive as a public patient; this despite the fact that much 'private' care is in fact delivered in public hospitals. The steady growth in numbers of privately insured Irish citizens is likely to be due to a combination of factors and events in the history of Irish healthcare. Whatever the causative factors, many of which will be explored in this thesis, what is certain is that the privileged position in terms of access to health care that is afforded to middle class privately insured citizens, and is incentivised or subsidised through taxation policies 'undermines entitlement as a material measure of social solidarity' (McDonnell & O'Donovan 2009, p.20).

The End of a Monopoly - Creation of an Oligopoly.

Following a European Council Directive in 1992, the Health Insurance Act (1994) paved the way to end the VHI monopoly so as to allow providers in other EU states to compete in the Irish Health insurance providers' market. Up to this point Ireland's health insurance market was entirely dominated by the VHI, a state owned corporation. VHI policyholders were persuaded to adopt misconceptions that this was something other than commodified health care. Such misconceptions were successfully created by the use of terms like 'community rating' and 'intergenerational solidarity'. However, with the market now opened up BUPA moved in so as to be the first insurer to compete with the VHI when they joined the Irish market in 1996. At this point everything changed as regards health care in Ireland. No longer could health 'cover' be seen as anything else other than a marketable and purchasable commodity to be traded on the market and subject to the attendant vagaries and effects of stiff competition. Media coverage at the time made much of comparing the policies offered by the two companies and in so doing failed to acknowledge that many of the circumstances catered for in these policies were in fact entirely provided for by the public health system. The discourse of choice resonated loudly from opinion pieces in newspapers and from comments of politicians, so loudly in fact as to entirely drown out the voices that called for improved quality of provision in the public health system. For example, a comparative piece in The Irish Times in November 1996, extolling the merits of the arrival of BUPA, refers to policies covering cardiac surgery and unashamedly enthused:

> 'This is particularly significant for people on lower incomes who will now be able to jump the lengthy public health service queues for such operations' (Kerby 1996).

In the same piece the correspondent goes on to describe how cancer treatments, radiotherapy etc. are covered by these policies, failing to even reference the fact that all such treatments are provided in the public system. In fact it would be questionable the extent to which private facilities in Ireland at that time had the expertise or experience to treat cancer. This influential discourse, therefore, reinforces to the

reader that to be enabled to jump a queue is desirable without any requirement to consider those waiting in a queue over whom one is advised to leap.
So, from this point onwards two very significant shifts can be seen to have occurred; firstly, health care provision was now seen as a legitimately marketable entity open to the vagaries of competition and secondly, the role of state in providing a universal welfarist model of healthcare was thus undermined and successfully eroded so as to be disregarded as an archaic and backward concept. Each of these related phenomenon are deserving of individual discussion.

The marketisation of health care

In 1998 a family finance correspondent writing in the Irish Times described the new dilemma facing Irish citizens following the entry of BUPA into the health insurance market. 'It is not a matter anymore of wondering whether you need private health insurance, but whether you need VHI or BUPA' (Kerby 1998). In one sentence this media coverage sweeps away any question over the necessity to purchase cover; this in fact is now a 'given'. The only issue for the citizen now is that they should exercise their choice wisely. Despite the fact that since 1957 health care coverage was already a purchasable commodity, this move by another provider created a new state of competition. It subsequently changed the manner in which health care provision and its related policy was conceptualised and it created an even deeper gulf between the two tiers of public and private health care.

Before this point a myth perpetuated that what had become known as 'the VHI' could be considered a form of solidaristic provision. McDonnell and O'Donovan (2009) examine this myth stating that it has been 'constructed and sustained by particular rhetorical strategies deployed around the meaning of 'community' (p. 7). So, heretofore Irish citizens were, to an extent, of the belief that by engaging in the limited state-sponsored health insurance market of the VHI, that they were actually demonstrating solidarity with fellow citizens. There is a certain irony in this misconception given that by establishing their status as 'private patients', they were, in fact, establishing a firm individuated status that ensured preferential and swifter health care; a far cry from an act of community solidarity. The instrument of 'community rating' was the mechanism by which this misnomer perpetuated, in

addition to the repeated reassurance to consumers of the absence of shareholders from the VHI structure. The VHI has always been at pains to point out that funds from premia are reinvested to the benefit of members and not used to reward shareholders. The inception of the alternative insurers in 1994 erased the illusion of solidarity and finally the private health insurance market could be seen for what it was; a market. These market conditions would exert competitive influence on both the customers and the providers. The customers could now 'shop around' and the provider must now deliver a competitively priced product.

Further competition was introduced to the Irish market when 'Vivas Health' became the 3rd health insurer in Ireland in 2004. In 2006 when 'BUPA' announced their plans to leave the Irish market, (due to their objections to the risk-equalisation scheme) they were acquired by the Quinn Insurance group. Prior to this, in 2001, the Health Insurance Amendment Act (2001) established the Health Insurance Authority who have a role in overseeing and regulating the health insurance industry in Ireland. They are also responsible for managing risk equalisation between insurers:
'Risk equalisation is a process that aims to equitably neutralise differences in insurers' costs that arise due to variations in the age profile of the insurers. Risk equalisation involves transfer payments between health insurers to spread some of the claims cost of the high-risk older members amongst all the private health insurers in the market in proportion to their market share' (HIA 2012).

The process of risk equalisation, common in countries with community rated health insurance, may fuel public and policy makers' perceptions of the degree of solidarity enabled through private health insurance. Those in the health insurance industry are perhaps more candid though. The CEO of BUPA, Martin O'Rourke, in an interview in 1996, stated 'health insurance is a good industry in which to work. It's about helping people when they are vulnerable and exposed. It's about selling security' (Canniffe 1996). The second part of this quote reveals the staggering reality of health insurance and the manner in which its associated security can indeed be sold to citizens, in their exposed and vulnerable condition, so long as they are in a position to buy. Such public discourse, (which, if examined closer, actually states that only those who can afford it, are entitled to security) was, and continues to be, rarely questioned or analysed. Few critics voiced objection to these distinctions that would

appear to be commonly accepted. Kuhling and Keohane refer to the Irish health system as '…characterised by reiterations of social distinction between private and public…' (2009, p.29). It is these reiterations that would seem to be so embedded into the caste system of Irish health care that can be traced back through the years of health policy decisions.

The nomenclature of free market economics can be seen to be fully embedded into the discourse surrounding health care and health insurance. 'Competition' for example, used as an unquestionable feature of efficiency and success in other areas of industry, has crept in to that of health care. The dominance of the VHI in the Irish market for so many years resulted in a situation where they held a massive proportion of the health insurance market and thus there was little opportunity for competition. This did not sit well with neoliberal policy makers. The Competition Authority in their report on competition in Irish health care reported that the potential for competition had been severely limited by the choices that Ireland had made in relation to intergenerational solidarity (Competition Authority 2007). More recently, Boate (2011) in a paper reportedly reviewed by Department of Health officials recommends that, with proper regulation, competition is 'entirely compatible with healthcare policy' (p.339). Enthoven (1993) defines managed competition as a purchasing strategy that is derived from rational microeconomic principles, however he warns:

> 'A free market does not and cannot work in health insurance and health care […] this market is plagued by problems of free riders, biased risk selection, segmentation, and other sources of market failure' (p.44).

Despite such warnings, neoliberal policies, with their attendant managerialism, have endured in Irish health care strategy (Skillington 2009). The continued incentivisation and subsidisation of private health care has the effect of undermining and devaluing the public health service, and persuading the citizen that there is something justifiable in providing a poor public service for the poor.

The rejection of state-provided health care

Mc Donnell and O'Donovan (2009) interpret the influence the contemporary discourses have had on public perceptions of publicly provided health care, and they explain that:

> 'the myth of community masks a neo-liberal rationale in which PHI [private health insurance] is increasingly seen as an obligatory action of responsible citizenship' (p.7).

This myth was perpetuated by discourse originating from both within and outside of the establishment. These sentiments succeeded not only in promoting uptake of private health insurance through the VHI following its establishment in the 1950s, but it also succeeded in establishing a firm link between self-reliance and responsible citizenship. This simultaneously established a strong rhetoric of anti-welfarism that sought to undermine any possibility of universality in a publicly funded health service. What came to be known as 'having VHI' was seen as a demonstration of one's independent status and prudent decision-making. Like a new car, it showed affluence, success and an ability to provide for your own or your family's needs. In a society that was beginning to respect such values, especially during the 'Celtic tiger' era, there was no appetite for a publicly funded universal health service. The consequences of this thinking, particularly the stark reality that poor individuals would not get timely health care, was largely unrecognised by most citizens. They were, after all, being assured by the discourse of their elected representatives, by media, by the market and by advertisers that they were entitled to privileged health care because they had paid for it. The harsh inequalities would not be publicly aired, and when some unfortunate case did emerge, such as that of the late Susie Long, those responsible for inequitable policies would swiftly distract questioning citizens through smokescreens of side issues such as consultants' contracts, system failures, adverse events and rogue practitioners. Such avoidance mechanisms are illustrated by McDonnell and O'Donovan who state:

> '…the language of functionality proves to be one of the central symbolic mechanisms used by government to insulate itself from an

> over-engagement with the glaring reality of health inequality and sustain a deeply embedded policy tradition of non-accountability' (McDonnell & O'Donovan 2009, p.98).

It is worth examining current perceptions of health care and health insurance and exploring the extent to which these have been influenced by the history of Ireland's system and the arrival of multiple insurers. Consider, for example, this extract from a post on the popular online discussion forum Politico.ie from January 2011:

> 'For all the gassing people do about health care, when presented with a choice none of us actually wants to share in the health costs of others. […] I don't think younger folk in this country owe any debt to our smug, complaisant [sic] pensioners. I heard some of them on the radio, sounding shocked that the society they built - which specialised in quietly ignoring the needs of weaker people - is now noisily ignoring theirs' (http://www.politics.ie/forum/health-social-affairs/147441-vhi-why-we-so-blind.html *Accessed 04/10/12*)

Taken from a thread titled 'VHI - Why are we so blind', this discussion explored the area of community rating and went on to question whether, with higher premia, they were subsidising the care of other older VHI members with greater health care needs or whether they were subsidising their needs for when they themselves were older. This interesting distinction goes right to the heart of the concept of solidarity and intergenerational solidarity that is held up as distinguishing feature of the VHI scheme. Such intergenerational solidarity had been 'hacked away' according to one writer in the Irish Times in 2003, under a provocative headline referring to a ticking time bomb (O'Brien 2003) who then goes on to wonder what future lies ahead for the generations that were encouraged to be independent and self-supporting.

An editorial in The Irish Times in 2007 stated that half the population 'needs private health insurance' (Kennedy 2007). This is one of numerous examples of public discourse that make the assumption that private health insurance is necessary, and thereby validates the inference that the public health system, and the social inequity

therein, is not even worthy of contemplation. Habermas had warned of such a consequence in an interview with Michael Haller, when he stated:

> 'The price of admission into a market economy has to be paid in the currency of social inequity, entirely new kinds of social divisions, and in higher long-term unemployment' (Habermas & Pensky 1994, p.55)

The powerful force of the market, as it manifests itself in Irish health care, has succeeded in fluently cementing social divisions and inequities so as to make invisible the very fact that any other world could exist, other than that which is unequal. The consequences of the social and political assumptions that follow such divisions and inequities are borne by those with least powerful positions and often those experiencing the most vulnerability. Other fellow citizens continue their individualised existences unaware that the inaudibility of any critical voices from their ranks is perceived as an acceptance of the status quo and their acquiescence to the dissolution of a social contract is assumed. The following case of Susie Long exemplifies the fatal effects of this situation and illuminates the apparent unawareness of her fellow citizens that their health system was so inequitable and that the gift had been so utterly corrupted.

Susie Long

Susie Long was a young mother of two children who had moved to Ireland from the US as a teenager. She and her husband believed that it was wrong for those with private health insurance to be treated any differently than those without it and for this reason they did not purchase private health insurance for themselves. It could be said that they believed in the deep value of a social contract. In the summer of 2005, feeling unwell, she visited her GP reporting worrying symptoms and was referred to her local hospital for a colonoscopy; a vital diagnostic test. Susie waited for this test and, as she began to feel increasingly unwell, repeatedly contacted the hospital only to be told she was on a waiting list. When she was finally called for this test, the 7-month delay in reaching a diagnosis of bowel cancer was proven to have been fatally prolonged. She was swiftly diagnosed with bowel cancer and a scan later showed that it had spread to her lungs. She was commenced on a chemotherapy regime and was given a life expectancy of, at most, 3 years. While attending hospital for her chemotherapy she met a woman she knew whose husband was also having treatment and who had experienced very similar symptoms. However, Susie learned that he had only had to wait a few days for his colonoscopy because he was a 'private patient', i.e. he had purchased a private health insurance policy. Furthermore, because of the early diagnosis of his cancer this man's prognosis was good and he was expected to make a full recovery. In essence, his financial status had bought him a more prolonged life than he might have had.

Susie Long, while pleased for this gentleman's good fortune, was incensed by the inequity of this situation. She was driven to contact the presenter of Ireland's popular radio chat show, Joe Duffy, to whom she wrote a most impassioned depiction of her situation and her subsequent frustration. Her email told of her anxieties about her family

> 'I have 3 years, tops, to go. Despite that, I'm going to try my best to make it for 5 more 'til my youngest turns 18. He needs me too much now. My husband has suffered right along side of me in his own way knowing that the woman he loves will be dead soon. My 18-year-old daughter has been told and has gone quiet and doesn't want to talk

> about it. But I know she's scared. I haven't told my 13-year-old son yet. He's too young to handle it' (RTE 2007)

After her email was read out on air the show was inundated by calls and texts from listeners who were moved by her plight, many telling of similar stories. Initially Susie had written under a pseudonym 'Rosie' as she had not yet told her adolescent son of her poor prognosis, however, eventually she calmly faced publicity as she spoke live on the air to Joe Duffy and subsequently to other media. Her case was taken up by opposition politicians who demanded that the Minister for Health, Mary Harney, explain why her test had been so dreadfully delayed. The minister responded by referring to the issue of the consultants' contracts as being influential in improving the care of public patients and saying that 'the issue of how patients access hospitals is central to the new consultants' contract of employment' (Oireachtas 2007). The consequent media coverage of her case resulted in a laying bare of the realities of Ireland's two-tier health system. Others joined in with further stories of inequitable access to healthcare, while demands for reform were heard from pressure groups and opposition politicians. In response the Minister for Health claimed that the process of negotiating new contracts for consultants was almost complete and, she suggested, this was a major factor in the situation. By doing this she laid the blame for Susie Long's tragedy firmly at the feet of the medical profession and it's consultants. This explanation located greed as a core driver of the inequity and introduced the notion that market forces were of relevance to the health outcomes for Irish citizens. Here a social contract between state and citizen could be seen to have become corrupted by the powerful influence of fiscal matters.

For Susie, her situation provided an opportunity to shine a light on the inequitable two-tier system that had become broadly accepted by Irish citizens. She felt deeply that every person should receive timely investigations and treatments regardless of their ability to pay for insurance. She selflessly utilised her tragedy so that a more fair and just healthcare system might be demanded. In essence Susie's case demonstrated an instantiation of the failure of a social contract due to an absence of trust. She had trusted the state to provide her with protection and stability at a time of vulnerability, but found this trust to have been misplaced. She then sought to alert others to this failure and to starkly demonstrate, altruistically using her own mortality,

the injustice that had resulted from the breaking of the social contract. She sought to establish solidaristic links with others that might together seek to influence change in Ireland's health care system. It was her already existent sense of solidarity that had resulted in Susie rejecting private health care. The focused individualism and self preservation that drives one to insure against ill-health, she believed, was at odds with her sense of solidarity:

> 'Solidarity is maintained by recognition-based social relations such as love, friendship, trust, empathy and compassion, charity, altruism and mutualism and the willingness to make sacrifices for others' (Powell & Guerin, 1997,p.).

Susie continued to campaign on the issue of equitable access to health care even after she was admitted to a hospice for palliative treatment. Joe Duffy who had maintained contact with her and visited her there, reported later that she was eager to know whether her efforts had made a difference. He assured her that she had. Susie died on the 12th of October 2007 only 20 months after her diagnosis. Her death was reported on national media and was brought up in the Dáil where once again the Minister for Health was under pressure to explain how this had happened and what she would do to ensure it never happened again. Again the consultants' new contracts were referenced, as were planned improvements to the endoscopy unit in Susie's local hospital. The Taoiseach, Bertie Ahern, responded to questions about her untimely death by suggesting 'the system had failed her', a statement that led to widespread criticism. A letter writer to the Irish Times, for example, wrote:
'Mr Ahern's reaction is an insult to the memory of Susie Long. It wilfully ignores the injustice she suffered by choosing to put her faith in the public health system' (Walsh, Oct 26th 2007).

Another letter writer wrote:

> 'Mr Ahern has been in power longer than any other politician and he has had at his disposal enormous amounts of tax revenue…. had he decided to make our public health service a priority he undoubtedly

> could have made a difference. He has chosen not to prioritise health and the result has been the unnecessary and avoidable death of Susie Long and, most likely, many others like her' (O'Dubhain, Oct 26th 2007).

Another letter writer pointed out that, in fact, the system had not failed but that it had done precisely what it was designed to do; it was a two-tier system and she, as a public patient, had been treated accordingly by this system. Public discourse bore witness to the fact that his own party had, for the previous 10 years, presided over the establishment of this failing system and was at the time pursuing a blatant neoliberal agenda that promoted investment in the private sector of Irish health care at the expense of a neglected and crumbling public health system. The discourse surrounding Susie's case provides an interesting insight into public perceptions of health and conceptions of obligations of the state on the one hand, and entitlements of citizens on the other. Issues of the private and the public were brought to the surface of public discourse with the actuality of Susie's illness and death providing a stark backdrop of reality. Those attending to this discourse were forced to stop and examine the underlying structures in Ireland's health care system and to question their validity. Where, they had to ask, was the evidence of a socially just system? How could it be that longevity could be purchased? Why have we accepted this system in its current inherently unjust and inequitable format? Why do we feel no sense of solidarity or mutuality with those who cannot afford private health care? From where has come our sense of purchaser's entitlement?

In an interview with the Irish Times in 2007, the renowned author Naomi Klein referred to Susie Long's story as exemplifying neoliberal health policies, suggesting that it had led to public questioning of the logic of Ireland's two-tier health system (Slattery 2007). Whether such questioning would result in a revision of the inequitable system was yet to be seen. Pressure groups and opposition parties cried for a reform of the health system in terms of improvements and reduction of waiting lists, but few called for an entirely new system that would provide free and equitable health care. The government's references to the consultants' contracts had effectively provided a smoke screen that enabled the underlying reality to remain hidden. Those calling for reform demanded a reduction in waiting times for public

patients, but at no time in public discourse was there an acknowledgment that the very structure of the health system was unjust in its two-tier structure. Instead of any public acknowledgment that anyone who needs a colonoscopy should get one, there was, instead, clamorous calls for revised waiting-time targets. In other words, there would always be a private swift route to treatment, and then there would continue to be the public route; which we would try to improve upon. But no-one cried for a merging of the dual system of the private and the public; this would have required a complete reconceptualising of what health care is, ought to be, or could be.

This exemplar provides, therefore, an excellent example of the manner in which the layering of discourse surrounding health and health care entitlements has succeeded in narrowing the focus of citizens, critics and observers. A consultant oncologist reviewing an influential book on Ireland's health care system (Burke 2010) in the Irish Times in 2009, refers to inequality as being 'built into the bedrock of the Irish health system' (Crown 2009). The geological phraseology used by Professor Crown reflects the manner in which the layering of discourses succeeds in setting down the foundations upon which future perceptions and beliefs surrounding social policy issues, such as health care, are built. The very targets identified by those seeking improvements in the health care system in the wake of the Susie Long tragedy can be seen to fall short of aiming to achieve actual equality of access. Instead the targets set merely persisted in the maintenance of a socially and morally inequitable system that was based entirely on economic terms and failed to engage the gift relationship. The inequities in the current system will persist until the dual modes of funding of health care in Ireland are combined (Barton 2008).

Much of the discourse surrounding the Susie Long case can be seen to have been running counter to that of the sound bites and rhetoric of the health insurance industry, as discussed in the previous genealogy. However, while the voices of those empathising with Susie's plight are impassioned and genuine, they are no match for the dominance of the neoliberal hegemony that has fuelled Ireland's embrace of private health care. This ardent individualism promises to position the actor in the market in his rightful place, that is, ahead of others, however precarious their predicaments. Furthermore, neoliberalism seeks to erase any intuitive notions the subject might have of an obligation to socially support someone weaker or more

vulnerable. They had their choice too. Your responsibility in this marketised world is not to the community but to be socially responsible by engaging in the market and purchasing your care. Susie Long, as a failed consumer, was a collateral victim of consumerism (Bauman 2007). She had failed to join this club of the privately insured so therefore she was not a recipient of the solidarity afforded to its members.

> 'The narrowing of solidarities into clubs serves to exclude those who cannot make the required contributions of membership because they lack material resources and other capacities, and because they face higher risks' (Macmillan 2011, p.109).

The work of Bill Jordan on the theory of clubs and their socially exclusionary effects, can be seen to be particularly significant here. He argues that social fragmentation is occurring in direct proportion to increasing adoption of free market economics in social policy making. Such fragmentation creates a situation whereby citizens 'sort themselves into new social formations' (Jordan 1996, p.68) and in a similar manner we can see that the gradual degradation of the health care portion of Ireland's welfare state has resulted in Irish citizens forming new clubs in the form of private health insurance. A club-theoretic analysis is very useful here and is developed further in Chapter 7.

The emphasis on individual responsibility is not an exclusively Irish phenomenon, in fact, it can be seen to have affected even those countries with welfare systems that are highly regarded, such as those of Scandinavian countries. Michailakis & Schirmer, for example, use illustrations from the Swedish health care system to demonstrate that there has been a significant shift from collective responsibility to individual responsibility (2010). They identify that this shift has happened through the use of what they call 'communicative structures' that serve to 'legitimise the attribution of individual accountability and make normal the expectation of individual responsibility regarding health' (p. 932). Similarity can be drawn here between the description of 'communicative structures' by Michailakis & Schirmer, and Foucault's illustration of the use of discourse as a subtle mechanism of power or a lasting system of representations. Both of these structuralist descriptions of the potentially

undermining strength of such discourse to influence thinking on, in this case the notion of individual responsibilities, emphasise the ability to challenge previously held assumptions. Furthermore this is done through the use of language to reverse the relationship of forces.

It could be suggested, therefore, that this latent function of encouraging responsibility for ones own health, is part of a greater shift towards individualisation that is similarly seen in official responses to health inequalities, such as the focus evident within public health research. Davey Smith (cited in Krieger 2005) warns of this increasing focus on the individual and cites Schwartz & Carpenter (1999) who warned that an increased focus on inter-individual variations in epidemiological research was erroneous as it:

> 'has value-laden and political implications because such analyses, implicitly or explicitly, consider ubiquitous exposures uninteresting, unchangeable, or outside the purview of epidemiologic consideration' (p.1179).

By failing to focus on the macro-sociological influences on health there is a risk that epidemiological research succeeds in 'getting the right answer for the wrong questions' (Schwartz & Carpenter 1999).

Analysis and Discussion of the Four Genealogies

The genealogical narratives of moments and events in Irish health care outlined in this chapter serve as illuminating epiphanies of the dissolution of the social contract in favour of privatisation and individualism. The varying discourses of politics, policy, media and the citizen demonstrate the manner in which the Irish citizen has moved from being a subject with rights and entitlements in the presence of a robust social contract, to being merely an actor in an individualised market. The commodified version of health care is starkly at odds with the version that is expounded through the gift relationship.

These case studies are four of a multitude of examples that could be used to demonstrate Ireland as a microcosm of possessiveness and individualisation, each of which is manifested in the current historical conjuncture that devalues the social contract and disregards the gift relationship. These exemplars help us to trace the genealogy of our current situation and illustrate the origins and progress of social and political assumptions. The realms of health and health care make the consequences of this individualisation more significant and touches at the very heart of human existence and that of life or death. The neglect of the social in favour of the individual engages the private individual in a position that can be reduced to one of effective barbarism with no conceptualisation of the collective or of solidarity. Instead, the focus is on the individual as a possessor.

Professor Joe Lee describes the period in the 1950s in Ireland when the 'possessor principle' had begun to take hold and become the 'glue' of Irish society. The possessor principle, he says, '…owed its power not to the whims of individuals, but to attitudes deeply rooted in social structure and historical experience' (Lee 1989, p.390). Lee emphasises that '…specific historical conjunctures' had shaped Irish society in this regard, but he argues that for this reason they could be changed again for the better 'by social engineers able to understand the lessons of history' (p.396). This possessor principle has been identified by other writers in the context of Ireland's social world. O'Connell (2007), for example, illustrates the impact of the possessor principle as it '…became relevant as an underlying conceptual influence' (p.xviii) in terms of state housing policies in Ireland. O'Connell's analysis of the housing situation can be seen to mirror, in many ways, that of the health sector in

Ireland, in that, he suggests, the influence of the possessor principle transformed Irish homes into 'things to be owned on a private and individualised basis' (p.xviii). In the same manner Irish health care has transformed from being an entity that might exist in the social world to the communal benefit of a nation, to being a commodity that is purchased by the individual.

While Lee argues that the possessor principle is not immutable and can be manipulated he clearly identifies its stultifying effects on society in terms of dissent or complaint.

> 'A society pervaded by the possessor principle normally responded more with apathy than anger to economic crisis, unless its possession of its property was directly threatened..' (Lee 1989, p.400).

An interesting and somewhat unique example of an Irish response to such a threat was seen in the 2008/9 budget when the Irish government announced a plan to remove the right to free medical cards to people over 70 years old. A significant protest of over 2000 elderly people and their supporters on the streets of Dublin on a cold October afternoon in 2008 resulted in a significant U-turn on the part of the government.

While these four genealogies are discrete cases, they are representative of disparate transformative moments in the history of the Irish health care system which have much in common. There are numerous vectors between these cases that serve to exemplify instantiations of the corruption of the gift and the erosion of the social contract through the insidious effects of individuation and neoliberalism. The matrix of connections between these genealogies include:

- the presence of market/neoliberal hegemony and its influence on social policies,
- the neglect of the citizen by the state as a consequence of increasing individualisation,
- the presence of powerful actors that effectively determine the health and wellbeing of the Irish citizen without their consent.
- the reversal of the relationship of forces so as to culminate in an absence of social justice in a marketised system.

Neoliberalism, already shown to be a significant force in the formation of Ireland's health care system, 'valorises the individual' and 'idealises the rationality of the individual decision maker' (Haggerty 2003, p.194). This embrace of the individual is theorised by MacPherson (1962) as 'Possessive Individualism' that reduces human interactions to little more than economic relations. The consequence of such possessive individualism is showcased through these four genealogies. The case of Susie Long, and that of the ushering-in of competition to the Irish Health Insurance market, share similarities in this regard. Both of these demonstrate exemplary cases of a neglect of the vulnerable so as to enable deference to the power of the market. In some ways the Blood Contamination case also demonstrates this consequence. The BTSB was being expected to perform safely in what was increasingly becoming a challenging market of blood and blood products. The subsequent treatment of the victims of this market, who were subjected to a further social injustice in their treatment by the state during their campaign for justice and recognition, typifies the consequences when the citizen is neglected in favour of more powerful actors. The thwarted efforts of Noel Browne also serve as critical examples of the neglect of the citizen. Furthermore, the discourse of the neglectful but powerful actors reveal the corruption of the social contract when individualisation is dominant.

It is the power of such discourse to alter public and social knowledge that Foucault emphasised as he saw knowledge as a matter of the social, historical, and political conditions under which discourse is seen to be true or false. This issue of veracity can be seen to have been significantly prominent in the case of the blood contamination debacle. The state and its functionaries failed to disclose fully and honestly the reality of the situation. Similarly the public discourse that contributed to the growth in the health insurance market can be seen to have utilised statements surrounding the necessity of individual measures, and to have repeated them often enough until they came to be accepted as true.

The discourse of individualisation is a key feature of the Susie Long case as well as that of the health insurance market in Ireland. Gordon (1991) relates such individualisation as a specific goal of neoliberalism when he says; 'It becomes the ambition of neo-liberalism to implicate the individual citizen as player and partner into

this market game' (p.36). Susie Long's death was, according to advocates of market forces in health care, a predictable consequence of her failure to engage as a player or partner in the market game. This message is clearly audible in the discourse from journalists and commentators when examining the statements surrounding the health insurance industry. The citizen makes a risky decision if they choose not to engage in this market and their consequent suffering can therefore be cast as self-inflicted. The modalities and discourses of dominant regimes, such as that of neoliberalism are seen therefore to have had a most severe impact on human conduct (Björnsdóttir 2002), that is to say, it has an impact on life itself.

Conclusion

The Foucauldian method used in this analysis has provided an alternative history of Irish health care. This historical method, while avoiding traditional historicisation, succeeds in challenging and disturbing the taken-for-granted and breaks the habit of looking for 'causes' of our situation; instead, accepting them as 'contingencies'. Foucault's work on the relationship between knowledge, power and human subjects is highly significant for this examination of Irish health care given the particularly powerful positions of many actors in these scenes. Hegemonic influences such as the Catholic Church and the medical profession have enjoyed perpetual positions of authority and control over many of the actors in these case studies and they thereby control the audible discourses. A further rupture could be considered to have occurred when these powers collided with another even more powerful force within their worlds; that of the force of the market in an increasingly neoliberal Ireland. The clash of these dominating forces has created an unusual conflict whereby each jostle for prominence in an increasingly globalised and capitalised world.

The following chapter will systematically analyse these genealogies through the lens of the core theoretical constructs that were examined in Chapter 4. Such an approach will enable a unique philosophical and anthropological perspective to be taken.

Chapter 7: Discussion & Analysis

Introduction

Examining Irish health care through the sociological and philosophical lenses of seminal theories such as the social contract, the gift relationship, possessive individualism and a core concept like solidarity, results in an unveiling of the deep historical legacy that contributes to the system that is currently in place. Through these core concepts, and the genealogical approach employed, the origins of the economic and social ideas that have created the current health and welfare conditions in Ireland are revealed. These narratives are useful in the examination of the situation precisely because of their shared lineage and interconnectedness. The political and human experiences of Noel Browne, Bridget McCole, or Susie Long did not take place in an Irish vacuum. Their lives were impacted by global as well as local influences, by the political as well as by the economic, by the social as well as the individual circumstances with which they were most familiar. It would be wrong to consider these stories as aberrations when in fact they are symbolic cases of injustices commonly experienced in Ireland and elsewhere. Their histories serve to illustrate the impact of their realities and help us to observe the reactions to them.

This chapter will engage in an original and systematic analysis of the genealogies of the previous chapter, treating the cases in an integrated manner that will serve to meet the objectives of this research in terms of tracing and explaining the origins of Ireland's health and welfare system, and to make explicit that which is assumed to be implicit in the conditions with which we are familiar. Therefore, Foucault's genealogical interpretation is an immensely suitable approach to have taken, given that it seeks to examine and challenge what is taken for granted. Foucault's interests in the identification of subtle and discrete invocations of power also contribute to the suitability of the genealogical analysis for this research. In addition, the tension in disciplinary power described by Foucault relates closely to the punitive turn observed in contemporary welfare studies (Brown & Baker 2012), contributing to a neoliberal agenda involving minimal state support.

While an archaeological analysis seeks to find evidence through excavation of what once remained, a genealogical analysis, like this genealogy of Ireland's health care, seeks to identify the influences that created the conditions for that which existed. Just as in a genealogy of a family's lineage, circumstances of birth of an ancestor can be seen to continue to exert influence on future generations long after a period has passed. Traditions and practices are changed by these influences and go on to be accepted, unquestioned as an incontrovertible norm. These conditions are crucial to an understanding of all that was changed and embedded through subtle powerful influence and of the uncritical assumptions that were made thereafter.

Systematic Treatment of the case studies

When examining the genealogies outlined in the previous chapter it is possible to distinguish a number of overarching macro themes. By this it is not meant simply that they share similar features, as they are bound to do by virtue of relating to Ireland's health care, but rather, that their analysis through the critical lenses of core concepts like solidarity, the social contract, the gift relationship and possessive individualism reveals related forces, discourses, transformations and manifestations. Of these forces and manifestations two broad core themes emerge particularly strongly, each with related secondary themes. This structure will serve as a framework throughout this chapter for the analysis of the genealogies that make up this particular history of Ireland's health and welfare system. It will then be possible to treat this history in a systematic manner that reveals a new and deeper understanding of the evolution of Ireland's health and welfare system, and crucially, an understanding that questions and challenges commonly held assumptions about the deeply inequitable and unjust system that exists today.

The first major theme or discourse that dominates these narratives is the attainment of apparent acquiescence to embedded social conditions resulting from a 'reversal of the relationship of forces', through the layering of normalising discourses. Related to this transformation of how social issues are conceptualised through discourse is the secondary, but nonetheless critical, findings related to the concept of individualism versus that of solidarity. The disparate distinctions of the prioritised individual in contrast with that of the collective emerge strongly from the genealogies in this

thesis. They provide engaging evidence of how Irish health care demonstrates reiterations of social distinctions between public and private, as well as ritualised indignities and humiliations. These too have become normalised.

Secondly, the complex play of hegemonic influences that act as powerful forces has emerged as a critical and dominant finding in this thesis. The play of such forces, including the church and professional powers, but also market forces, results in the cementing of social divisions and deleterious consequences for justice when commodification becomes hegemonic. Secondary to this major theme is a critical analysis of the role of the state under neoliberalism and how the social contract and the altruism of the gift relationship might be manifested in such a circumstance and in the presence of such influences.

The genealogies that make up the case study of Ireland's health and welfare system will now be examined in the context of these two dominant themes, along with their respective sub-themes and furthermore, the conditions of their possibility can be exposed by looking beyond the ideologies in question.

Normalising discourse achieves acquiescence

How has it come to be that the conditions of Irish health and welfare systems with all their iniquitous features are enabled to remain as they are? Is this an issue of power or capacity to make change? Is this a failure of democratic processes? Are citizens perhaps unable to see what it is they are enduring? Why is it that a group of young open-minded students discussing ethical principles in nursing, for example, shrug their shoulders and state that it is okay that those with health insurance get treated first? How does a multitude of health professionals involved in a cardiac surgery, for example, knowingly observe 'private patients' receive their surgeries ahead of a 'public patient' who dies in hospital awaiting their surgery? No one complains and no one protests about the inequality of the system; so do we therefore conclude that it is accepted and acceptable? Through an analysis of issues of discourse surrounding the four genealogies in the foregoing chapter, some answers to these questions are sought.

A genealogical examination is what Foucault refers to as an 'effective history', and it is effective because it succeeds in revealing the '…reversal of the relationship of forces and the usurpation of power, the appropriation of a vocabulary turned against those who had once used it…' (Foucault 1984, p.88) and such appropriation of vocabulary can indeed be seen in all of the genealogies, especially the discourse surrounding the Health Insurance Act. The expansion of the health insurance market to outside competition was presented in media coverage and in political commentary as representative of 'progress', and naturally the assumption that competition was inherently a good thing aligned this progress to neoliberal policy. Within this discourse, however, one can identify the misappropriation of solidaristic terminology such as 'community rating' and 'intergenerational solidarity' which served to feed into the myth that engaging in voluntary health insurance constituted an act of collectivism (McDonnell & O'Donovan 2009). This discourse erodes capacity for genuine solidarity and further promotes the centrality of individualism in a neoliberal economy. The attempt by the Taoiseach at the time of Susie Long's death to suggest that a 'system failure' had occurred is yet another example of the production of discourse intended to evade the truth. The minister for health's attempts to point to hospital consultants and their contracts as causative factor in Susie's delayed diagnosis sought to distract from the simple truth of the stark inequality of Ireland's two-tiered, market-orientated, health system. Similarly, in the blood contamination scenario officials evaded truth telling, until forced to provide evidence in a tribunal of enquiry, and furthermore misrepresented the issue as it was initially portrayed as a scientific interest issue rather than a human story. Farrell (2006) states:
'In early 1994 when the government announced that the contamination episode had taken place, it was an issue that was narrowly defined, by both the government and the media, in medical and scientific terms' (p.163).

A further aspect of the discourse surrounding the blood contamination scandal was the manner in which the government sought to abdicate themselves from responsibility for the mistakes made or the repercussions thereafter. While the government did organise a package of medical treatment and financial compensation for the women, Farrell (2006) points out that:

> 'The government emphasised its lack of "political culpability" in the matter, given that it was not legally responsible for the activities of the BTSB. By adopting this approach, the government sought to contain the financial, legal and political fall-out' (p.165).

A state seeking to avoid its obligations to its wronged citizens contributes to the discourse of individualism and, furthermore, erodes any beliefs in the function of a welfare state within a social contract that should compensate for the ills of the market. This individualised discourse seeks to portray the citizen as a consumer who has made a choice. This is a further example of appropriated language and it is clearly seen in the discourse of choice that couches public health and welfare firmly within the domain of consumption. Dean refers to consumerism, consumption and commercial choices as 'the paradigmatic form of choosing' within what she conceptualises as 'communicative capitalism' (Dean 2009, p.22).

In the Ireland of the 1940s and 1950s, during the struggles of Noel Browne, the make up of public discourse can be seen to have been rather different. The dominant position of the Catholic hierarchy in the Irish social world resulted in theirs being the predominant discourse through which Catholic social teaching was imposed and the means through which church domination was exercised. The historical picture of Catholic citizens failing to question a situation or to challenge its continuation encouraged a tradition lacking in critical interrogation, normalising acquiescence and interpreted as acceptance. Failure to question and challenge, while bowing blindly to the authority of the church has been seen to result in tragic and injurious circumstances. Attesting to this are the victims of institutional abuse in industrial schools and Magdalene laundries, children who were subjected to clerical sexual abuse in numerous dioceses, women who were subjected to symphysiotomy, and, still today, women who must travel outside of the state for abortion services. The tragedies of the 'Kerry babies' case and the death of Ann Lovett, a teenager who died in childbirth alone in a grotto in a midlands town, are described as watershed events in 1980s Ireland by Maguire (2001), who describes these as episodes that 'forced Irish society to confront, in a very public and self-conscious

way, issues that had long been considered unsuitable for public discussion' (p.353). She goes on to say:

> 'Few Irish people had given serious consideration to the nature of Catholic influence in virtually all aspects of Irish social, cultural, and political life, nor was there a particular concern for the extent to which an insistence on Catholic moral codes as the foundation of social policy marginalised and excluded those […] who found Catholicism a stifling and alienating force' (p.353).

That the Catholic Church has exerted a significant influence and power on Ireland's social policies is clearly without doubt, but it is not alone as a powerful force. Furthermore its hegemony over many decades is likely to have contributed to embedding a culture of unquestioning acceptance that enabled neoliberalism to also thrive when its turn came. The Irish citizen had already learned that their subjectivised place was one without significant voice and one which was to accept their 'lot' in life while bowing to a superior power or authority. Much of Foucault's work was concerned with just this type of historical layering of thinking and acting and the way that power is exercised through such discursive formations. Used as instruments of social order and control, hegemonic discursive formations succeed in oppressing and excluding.

One of the features of neoliberalism is its ability to allow citizens just enough to enable their survival without prompting social disquiet, as well as the ability to divisively turn spotlights on the 'other' who is to be blamed for conditions (the immigrant, the regulator, the welfare dependent), and to portray a situation where 'there is no alternative'. The increasing blame culture within health, welfare and within health promotion efforts, as has already been discussed in Chapters 2 and 3, contributes to these allegations and serves as further evidence of this consequence of neoliberalism in social policies. Educational systems, media and vested interests in political systems conspire to smother debate, critique and the proposals of alternatives. Margaret Thatcher's oft-quoted 'there is no alternative' was part of a response to a US journalist's question about monetarist policies in 1980 (Thatcher 1980), but has been since taken to reference variously the entire system of

capitalism, neoliberalism and market fundamentalism. However, the success of neoliberalism, this thesis argues, from the evidence of a largely acquiescent populace, is that it has rendered absent the social ability to interpret the need for, let alone the possibility of, any alternative. So Thatcher's catchphrase, now in an era of near-total capitalism, could be rephrased as 'we cannot see a need for an alternative'. This does not merely refer to the belief of those who follow an ideology, for that is precisely what any ideology succeeds in doing. Rather, this thesis argues, that those citizens subject to the social and economic policies instigated by followers of an ideology, that is citizens unconscious of their position of subjectivity to any ideology, have been vulnerable to invisible market forces that are assumed to naturally form the normal social world. This 'unknowingness' manifests when known truths are rendered opaque through consistent use of precise political narratives that can be seen to leak down into social discourse and thereby 'public knowledge'. An example of such usage includes the attribution in Ireland of the phrase 'the emergency' to what was to the rest of the globe a world war. Patomäki (2001) describes this process of unknowing saying:

> 'It is more helpful to analyse the resulting unknowing as a dynamic ideology - as systematic absences that make something essential unknown, not understood, hidden, distorted or simply undiscussed' (p.98)

The distorting capacity of discourse to control and to exert power was emphasised by Foucault in The Order of Discourse when he said:

> 'In every society the production of discourse is at once controlled, selected, organised and redistributed by a certain number of procedures, the role of which is to conjure its powers and dangers' (Foucault 1971, cited Paras 2006 p.49).

As was discussed earlier in Chapter 3, neoliberalism is successful in its ability to use technologies of power in order to dominate and subjectivise, through strategic normalising discourse. Neoliberalism and the Catholic Church thus may not merely

co-exist as mutually supportive powerful forces in Ireland, but perhaps could be described as exhibiting a number of analogous interests and methodologies.
Comparably, Margaret Somers (2008) identifies a number of similar parallels between market fundamentalism and religious fundamentalism. Firstly, she identifies that they both demand that core beliefs are accepted without the presence of scientific evidence and these imperatives take on almost 'mystical' properties as evidenced by notions of spontaneous order and the 'invisible hand' for example. Secondly, she points to their shared reliance on 'first or a priori principles' that are 'postulated as givens upon which whole systems are built' (p.77). She goes on to give the example of some core principles of neoliberalism, although she prefers to use the term 'market fundamentalism':

> 'To say that market principles (including individual choice and the utility-maximizing self) are fundamental, then, is to say that they are taken as the starting point for understanding how the whole social world works. Like the foundation of a building, everything else follows from it, is modelled upon it, and is limited by its principles and parameters' (p.78).

The final parallel between market and religious fundamentalism is that they share a need to maintain an 'inherent expansionary drive' because, Somers argues, the 'essential disposition of all fundamentalism is to expand and convert' (p.78). They do this through the deployment of 'cultural images, discursive codes, 'conversion narratives', and other ideational mechanisms' (p.80). Both these influential discourses of religion more generally, as well as Roman Catholic Social teaching, and of neoliberalism, while carrying divergent intentions, serve to leverage social thinking as well as policy makers, despite the absence of evidence to support them and with an 'astonishing immunity to the kinds of empirical challenges that should be evidentially disconfirming' (Somers & Block 2005, p.265).

Despite the absence of empirical evidence to support the truth claims of the market or the church, and despite the presence of what many believe to be a crisis in their respective legitimacies, both retain high levels of durability. Meanwhile the citizen is

subject to continued exposure to a rhetoric lacking in veracity. A further problem emerges when the authenticity of public rhetoric becomes so continuously doubted that all information is assumed to be biased. Jodi Dean (2009) examines the use of discourse through some sections of media, and identifies an evolving problem that emerges from contemporary cynicism surrounding the credibility of opinions that are put forward and an increasing suspicion around establishing 'truth'. Using the significant numbers who state a belief in a conspiracy around the September the 11th attacks, she refers to facts being 'introduced into a media environment wherein they are rejected or suspected in advance', and she suggests some are 'immediately presumed to be either lies in the service of ideology' that merely 'circulate primarily as eyeball bait in communicative capitalism's endless circuits' (Dean 2009, p.147). Dean's interpretation suggests, therefore, that consumers of media discourse retain a level of disbelief as well as an awareness of various agendas.

The communicative conditions that can be seen to have exerted influence in all of the genealogies in this thesis are numerous and complex. The discourse of neoliberalism with its emphasis on the economic, of the Catholic Church, of individualism and responsibilisation can all be referenced within these narratives. Through their use of particular language and symbols they serve to demonstrate public and political perspectives on the core concepts of solidarity, the social contract and issues of altruism, but they also serve to generate a normalising effect. Concepts, ideas and ideologies are fundamentally changed in the manner that they are understood by means of their narration and misappropriation. Thus the meanings and points of origins of these core concepts are altered by the '…symbolic language through which they are formulated and narrated' (Salvatore 2007, p.26). The consequence of this is to acquiesce those who find themselves subject to a marketed, commercialised social world and without the protective welfare concerns of an honoured social contract. Neoliberalism, in tandem with other relevant social forces thereby achieves its objectives and reaches its point of hegemony through, what Bauman (2001) refers to as, 'common consent' (p.67).

Solidarity versus Individualism

A central achievement of the normalising discourse explored in the previous section, is the endorsement and celebration of the self through individualism and the suppression of solidarity. All of the narratives explored in the previous chapter provide rich ground on which the ideas of solidarity and individualism can be analysed. The analysis of these themes also encompasses the related issues of altruism, choice, risk, responsibilisation, and distinctions of public and private. The overarching spectrum of individualism and solidarity is a range that is overly simplified as binary, but through the analysis of the genealogies such a simple distinction can be synthesised further.

It is useful at this point to clarify what is meant by these terms through an examination of some definitions used. In relation to health care Houtepen and Ter Meulen (2000) describe solidarity as referring 'to two interrelated connotations: a benevolent attitude towards weaker groups in society and a commitment to fair or even egalitarian distribution of health care services' (p.356). In 2011 the UK's Nuffield Council on Bioethics published an extensive report on Solidarity as an emerging concept in bioethics and outlined the difficulty with other terms being used synonymously with solidarity adding to a perceived vagueness about the concept (Prainsack & Buyx 2011). Their report defines solidarity simply as signifying 'shared practices reflecting a collective commitment to carry 'costs' (financial, social, emotional or otherwise) to assist others' (p.xiv), but they expand on this to develop a working definition that has what they refer to as three distinct 'tiers' of solidarity.
Firstly, tier 1, which they refer to as the 'Interpersonal level', applies to the level of individuals:

> 'At that level, solidarity comprises manifestations of the willingness to carry costs to assist others with whom a person recognises sameness or similarity in at least one relevant respect' (p.xiv).

Secondly, tier 2 relates to 'Group practices':

> 'On this tier, solidarity can be described as manifestations of a collective commitment to carry costs to assist others (who are all linked by means of a shared situation or cause). This is the second and arguably most prominent tier of solidarity. People who share a situation typically share certain risks or positive goals, which emerge out of, or define, that situation. People negotiate ways of conduct in that situation (p.xv)'.

The third tier is referred to as the 'Contractual and legal manifestations' where values and principles are not only thought of as socially important, but have been endorsed through law or contract into what can be regarded as the most solid of the three tiers of solidarity:

> 'Examples are welfare state and social welfare arrangements, but also contracts between different private actors and international declarations or treaties. While the lower tiers of solidarity can exist without the higher levels, higher levels do not exist without having been preceded by lower levels' (p.xv).

Prainsack and Buyx (2011) emphasise that solidarity should be distinguished from the feeling of empathy stating that although empathy can be involved in solidaristic practices, solidarity:

> 'takes the form of enactments of the willingness to carry costs to assist others. In this sense, solidarity is embodied and enacted rather than merely "felt"' (p.xv).

So from this recent examination of solidarity it can be seen to involve actions or practices rather than mere emotive identification with others, and it is realisable at the levels of individual interactions, group causes or through formalised modes. Häyry (2005) refers to solidarity as 'one of the most elusive concepts in contemporary social ethics' but goes on to describe solidarity as:

> 'a communal form of altruism, with a theoretical niche somewhere between the psychological, social, and political categories of sympathy, universal benevolence, and justice' (p.202).

The strength of the political within the concept of solidarity is emphasised by Scholz (2008) who identifies 'a system of classification of levels and types of solidarities' (p.4). Scholz defines Political Solidarity as:

> '…a unity of individuals each responding to a particular situation of injustice, oppression, social vulnerability, or tyranny. Each individual makes a conscious commitment to a cause' (p.51).

Thus, from the definitions examined here it can be seen that solidarity encompasses a wide range of ideas that broadly focus on altruistic consideration of others through actions triggered by empathy and related to the political sphere through social justice. Solidarity remains a challenging concept to universally define largely because of a recent history of widespread philosophical disinterest in the subject (Bayertz 1998), but also because of the manner in which it is somewhat at odds with a core pillar of dominant classical liberal theory; the view of humans as free, autonomous individuals. The concept of individualism could therefore be placed at the opposite end of a spectrum from solidarity. It has been defined as:
'A belief system that privileges the individual over the group, private life over public life, and personal expression over social experience; it is a worldview where autonomy, independence, and self-reliance are highly valued and thought to be natural; and it is an ideology based on self-determination, where free actors are assumed to make choices that have direct consequences for their own unique destiny' (Callero 2013, p.15).

But this is not merely a modern belief system. In 1840 Alexis de Tocqueville published the second volume of Democracy in America in which he described individualism thus:

> 'Individualism is a reflective and tranquil sentiment that disposes each citizen to cut himself off from the mass of his fellow men and

> withdraw into the circle of family and friends, so that, having created a little society for his own use, he gladly leaves the larger society to take care of itself' (de Tocqueville 1840, p.585)

More contemporarily, Hobsbawm describes individualism as a cultural phenomenon stating:

> 'The cultural revolution of the later twentieth century can then best be understood as the triumph of the individual over society' (Hobsbawm 1994, p.334)

The dominance of individualism's role in the dominant paradigm of neoliberal health and social policies in Ireland can be seen through the genealogies of the previous chapter. For example, the case of Susie Long and that of the expansion of the health insurance industry both illustrate this well. Susie Long assumed that a level of solidarity and collectivism existed in Ireland that would manifest in a universalist approach to health care provision. Instead, as she found to her cost, an individualistic approach to health and welfare, cultivated by neoliberalism, was dominant. Further examination reveals that such individualism is not only facilitated and encouraged by neoliberalism, but that the state in fact subsidises the private individualism that results through tax breaks and other measures discussed in Chapter 3. However, the responses by others to Susie's experience demonstrated that while the type of solidarity identified by Prainsack and Buyt (2011) as being the most 'solid' of levels of solidarity, normally provided by the state through a social contract was lacking, the solidarity of the individual level and the group level however remained strong. Susie Long was strengthened by messages of support and solidarity that she received from individuals who identified empathetically with her situation and who wished to form groups and take action. This response can be seen to align well with Häyry's (2005) definition of solidarity as a communal form of altruism, as well as with Scholz's (2008) definition that engages a response to a particular injustice. The blood contamination case, or more correctly, the collective actions of injured citizens, also serves to model fully Scholz's Political Solidarity as the formation of 'Positive Action' models the commitment of those involved to seek a correction of the injustice and social vulnerability suffered.

The expansion of the health insurance providers in Ireland in 1994 that removed the monopoly of the VHI is a further illumination of the hierarchisation of the individual within the contemporary social, political and economic world. The individualised citizen is described and promoted as the ideal type resulting in an undermining of the collective. Rather than citizens engaging in a solidaristic arrangement that provides for all, instead the responsibility of provision of care at a time of vulnerability shifts from the state, who has been encouraged to remain ultra minimal in line with liberal influences, onto the individual subject. This responsibilisation is sold to the citizen as a virtue that infers a sense of 'choice' and 'freedom' to choose, but one with a very narrow and limited understanding of 'freedom'. Private health insurance is 'increasingly seen as an obligatory action of responsible citizenship' (McDonnell & O'Donovan 2009, p.7). The discourse surrounding political support for increasing privatisation of health care in Ireland is packed with this language of responsibility, choice and freedom to choose. Alongside, and dependent on this discourse of responsibleness is the notion of risk, the risk society and subsequently the individualisation of risk. The society preoccupied with identifying and predicting risk, the 'risk society', is a fragmented one (Murphy-Lawless & Quin 2004). Rose (1996) makes explicit this connection between risk and responsibilisation stating:

> 'The ethics of lifestyle maximization coupled with a logic in which someone must be held to blame for any event that threatens an individual's "quality of life" generates a relentless imperative of risk management not simply in relation to contracting for insurance, but also through daily lifestyle management, exercise and so forth. Of course, this inaugurates a virtually endless spiral of amplification of risk … these arrangements within which the individual is re-responsibilized for the management of his or her own risk produces a field characterised by uncertainty, plurality and anxiety, thus continually open to the construction of new problems and the marketing of new solutions' (p.343, 346).

So not only does the discourse of responsibility and risk garner support from the individualising effects of neoliberal economic models, but the process also serves to heighten the tension between the individual and their place within a risk-filled social world. Discursive systems such as this succeed, Foucault argues, in locating individuals as:

> 'the product of highly rationalised discursive systems; they were the effect of a modern configuration of power' (Paras 2006, p.103).

This 'disciplinary power' that Foucault identifies is made more potent by its obscurity, in that it is hidden behind its facade of choice and freedom. The obscurity of Foucault's disciplinary power is not unlike MacPherson's idea of concealed class domination in liberal democratic theory and through market relations (Townshend 2000), in that, both involve discrete use of power and the dominance of one group over another. The domination of a poorer social class can be seen very clearly in the case of the Mother and Child Scheme, for example, when 'The Irish Medical Association disagreed with the Minister's proposals: dispensary doctors stated that they would not see poor patients in their private surgeries, designed for paying patients' (Adshead & Millar 2003, p.12). Throughout Ireland's health and welfare system the dominance of the private individual over the public indicates the success of such power and domination. Foucault saw human individuality as a tool of oppression and domination saying:

> 'I think that individuality is today completely controlled by power, and that we are individualized, at bottom, by power itself. In other words, I do not believe in the least that individualization is opposed to power, but on the contrary, I would say that our individuality - the obligatory identity of each of us - is the effect and instrument of power' (cited in Paras, 2006, p.78).

Ulrich Beck (2007) describes individualisation as a macro-sociological phenomenon that does not involve any 'conscious choice or preference on the part of the individual' and he emphasises that, 'the crucial idea is this, individualization really is

imposed on the individual by modern institutions' (p.681). In the case of Ireland's health and welfare, the modern institutions of the health system, the welfare state, the taxation system as well as social and economic policies can all be seen to be imposing individualisation in the manner to which Beck refers. The systematic practice of this imposed individualisation erodes social solidarity and fails to encourage altruism.

Examining Durkheim's theory of social solidarity, Slattery (2003) states that, 'man is as capable of altruism as of greed and the role of society is to encourage as much as to restrain such human traits' (p.73). Greed and power can be seen to be central to the failure of the Mother and Child scheme. In this case the dominant professional power of General Practitioners, coupled with the hegemony of the Catholic Church in Ireland at that time, combined to prevent a scheme that would have placed much responsibility for the welfare of vulnerable women and children with the state. A trace of misplaced solidarity can only be seen where the medical profession and the church could perhaps be said to have shared a collective commitment in their battle against what they claimed was 'socialised medicine'. Saving the state from its involvement in the on going care of mothers and babies of Ireland, the powerful forces returned the responsibility of dealing with the risks inherent in the economic system to the individuals and their families.

Such responsibilisation can be seen therefore in all of the genealogies examined. The corollary of such responsibilisation is the attribution of blame to those who fail to exercise their 'freedom of choice':

> 'Societies and ideologies where individuals tend to be blamed for their own vulnerabilities (e.g. because they have not insured themselves individually against this scenario) are less conducive to solidaristic practices than societies where vulnerabilities are seen as an inherent part of human and social life against which societies best protect themselves collectively' (Prainsack & Buyx 2011, p.48).

The net result of a blaming culture in the presence of vulnerability can be seen in the case of the women infected with hepatitis through contaminated blood products. Once again the responsibility of the citizen was an individual one and the state responded vociferously to the individual citizen Bridget McCole. Interestingly though, once more the tiers of solidarity of the interpersonal level and the group level remained strong in this case demonstrating an immense human capacity for solidaristic and altruistic tendencies. Such levels of solidarity cannot be seen very clearly however when examining the failed Mother and Child Scheme through this lens. Dr Noel Browne exhibited empathy with those who were poor and recognised a need for solidarity with those requiring free health care, however he failed to win substantial support for his scheme, demonstrating a lack of mass solidarity on the part of his political colleagues. It is important to note though that in 1950s Ireland there were few who questioned the dominant power of the church or who would challenge the medical profession on their fears of welfare statism. The truth of the real motivations behind the objections to the Mother and Child scheme would only be revealed in later years and has been the subject of much historical analysis.

It is clear therefore that the four genealogies enable us to study the conditions that have led to the emergence of particular discourses and practices (Björnsdóttir 2002) in Ireland around individualisation and solidarity, as well as the related issues of responsibilisation, risk and altruism. But to what extent is it correct to employ a dichotomous framing of these concepts? It could be argued that solidaristic actions could be motivated by self-interest, with the individual seeking justice for a cause in which they may have an individual vested interest. This suggests the two concepts are not exclusive of each other. Scholz (2008) draws the two concepts more closely together when she says:

> ‘Solidarity is both a personal commitment and a social commitment. The merger of individualism and collectivism must keep sight of both the individual and the collective’ (p.75).

Solidarity has been described as a phenomenon that is ‘born of struggle’ but it is also one that exposes a prima facie tension with liberalism (Butler 2012). The dominance

of contemporary neoliberalism, with its origins in classical liberal theory makes for an unsteady ground on which solidarity might stand.

> 'Classical liberal theory… views humans as autonomous, free individuals. Equality and liberty are ruling ideals as individuals pursue their own vision of the good life. Decisions are based on rational self-interested deliberations and at least some relations are formed through contracts' (Scholz 2008, p.75)

It has been suggested that solidarity also exhibits contractual-like features that might be assumed to belong more correctly to the realm of individualism. Pasini and Reichlin (2000) examining solidarity in the Italian health service, distinguish between the public solidarity of the welfare state and the private solidarity of the welfare community or society:

> 'Public solidarity is somewhat a "contractual" one: it does not build on the existence of strong bonds between individuals, nor on altruistic relationships, but on a universalistic drive toward removing inequalities or disadvantages between social groups through the redistribution of social resources' (p.343).

They go on to indicate that the crises of the welfare states in Europe and beyond has forced a rethink of the extent to which states can continue to provide universalist redistributionist welfare using the same model of public solidarity. They suggest an alternative that would seek to:

> 'get over the private/public and the market/State dichotomies, and to centre social arrangements on the voluntaristic dimension, in which the transactions between the members of society are mutual and involve families, relative networks, voluntary groups, mutual-help and self-help groups and so on. This has been called the model of societary-citizenship, because of its focus on relations taking place in

> the civil society and of its emphasis on activities of both primary (e.g. family) and secondary (voluntary groups) solidarity' (p.345).

While modifications to health and welfare provisions in line with societal changes need always be considered, in the presence of strong market forces it is likely that a shift in social arrangements to outside of those statutory universal needs being met by state provision, would fall victim to the profit seeking priorities of the private sector. Such outcomes can already be seen in the US where cost has placed private health insurance beyond the reach of huge swathes of American people.

In recent years solidarity has enjoyed renewed academic and political attention in political culture as a result of Blair's suggestions of a 'Third Way' which would:

> 'enable people to take responsibility for themselves and to participate in social and cultural structures with a minimum of state interference. In this approach solidarity stands for inclusion and empowerment of individuals instead of the dependency on support by the state' (Houtepen 2000).

This move to thoroughly activate neoliberal individualism among citizens is a distortion of individualism into a form of solidarity. The 'empowered' citizen who looks after their own needs without recourse to state support, is portrayed as acting in some benevolent altruistic manner that identifies with the characteristics of solidaristic tendencies. Here again the realms of solidarity and individualism enjoy some blurred space at their margins.

Hegemonic Influences

A number of hegemonic influences can be seen to have been revealed through the genealogical examination of the four cases in the previous chapter. The indomitable powers that are particularly relevant to this analysis are that of the Catholic church, the medical profession (particularly hospital consultants), and finally, and perhaps most potently, the force of the 'free' market that have enabled the conditions of neoliberalism. Other related sources of influence that are outside of the scope of this discussion could also be identified as including the broadcast media, including

Ireland's national broadcaster, the print media, the political elite (including high ranking civil servants who inform policy), well-positioned lobbyists working on behalf of those with vested interests and the force of globalisation. In many ways, this portion of the analysis of influential forces within the cases, could easily be dominated by the singular force of neoliberalism. However, while this would prove interesting, it is likely that it would fail to indicate specific distinctive responses to the increasing influence of neoliberalism by various other actors and forces, such as the state and the church. Instead this section will build on the discussion at the opening of this chapter and will take the position that neoliberalism has by its omnipresence become a mode of operating for the other forces that will be discussed here. The extent to which these forces might have intentionally adopted a neoliberal approach is debatable, but it is at least possible to trace the provenance of learned behaviours and attitudes back to earlier ideologies of classical liberalism (as discussed in Chapter 3), and to capitalist beliefs surrounding property and wealth. However, for the purpose of this analysis, neoliberalism as a dominant force is assumed to provide the context for the other historical forces that are visible in the cases discussed in the previous chapter. This conceptualisation of neoliberalism as a hegemonic force corresponds with the meaning of cultural hegemony originally intended by Gramsci, who referred to means of maintaining and legitimising the capitalist state. Gramsci refers to 'the intellectuals' as 'functionaries' who exercise power throughout society due to their dominant position. He describes the process involved in this attainment as:

> 'The "spontaneous" consent given by the great masses of the population to the general direction imposed on social life by the dominant fundamental group; this consent is "historically" caused by the prestige (and consequent confidence) which the dominant group enjoys because of its position and function in the world of production' (Gramsci 1971, p.12).

Dominant forces such as the medical profession and the church hierarchy might fit well into this description of 'the intellectuals' and they historically would certainly have enjoyed a level of prestige and respect from a society that enabled their

influential positions. Dr Noel Browne was in no doubt about the extent of the Catholic Church's influence over issues of social and economic concern when he wrote in his embittered memoirs:

> '…the pretence of a cabinet to be the supreme instrument and authority in the state, when in fact it was subject to an outside non-elected pressure group, was to me the supreme deception' (Browne 1986, p.185).

Turning back specifically to health and welfare issues, Murphy-Lawless and Quin (2004) identify the role of historical forces that have created inequities in Ireland's health care saying:

> 'Traditionally the Catholic Church has played a major role in ensuring a residualist approach to public provision in health care. Not only has it intervened on a policy level [Mother and Child Scheme], but, through direct provision, has created and reinforced a two-tier system of public/private provision in both health and education services' (p.139).

However, Murphy-Lawless and Quin do not lay the blame entirely at the door of the Catholic church and they acknowledge the influence of many of the forces referred to above. Similarly, Geoghegan and Powell (2006) identify a number of historical forces that have influenced and shaped Irish social policy including Catholic corporatism, nationalism and the modernising agenda of the state. J.H. Whyte also appears to concur on the notion of the church as just one of several forces likely to be of influence, however he argues that the church's hierarchy should not be seen as just another interest group:

> 'The analogy between the hierarchy and other interest groups breaks down because, in a mainly Catholic country, the Catholic hierarchy has a weapon which no other interest group possesses: its authority over men's consciences' (Whyte 1980, p.368).

He goes on to conclude that it is difficult to define the extent of influence the hierarchy exerts on Irish politics but that it is most likely dependent on other co-existing forces. The Mother and Child scheme is a case that demonstrates well the involvement of more than one hegemonic influence that can be seen to have had a mutual impact. In this case the forces of the church and the medical profession were not merely mutually coexisting in their influence on the failed scheme, but they were in fact, as records later showed, intentionally collaborating against a shared antagonist. What was it that proved particularly lethal about this joining of forces? Most significantly, what must be appreciated is the extent of power and popular respect that these two bodies held in the Ireland of the 1950s.

The church, as Whyte (1980) alluded to, possessed great authority over individuals, families and their communities to an extent that, as Gramsci noted, in cases of such dominance, citizens had great confidence in church opinion and generally did not dream of questioning their authority. A similar popular level of respect was seen to be given to those in the medical profession. So here their combined authority succeeded in muting any public questioning of their position on the Mother and Child scheme. Noel Browne effectively fought almost alone against both of these hegemonic groups and had the added burden of disputes within his cabinet to contend with. Meanwhile the poorer social groups, for whom he was largely fighting, did not openly support him (save for some words of support from some trade unions) as to do so would have implied their opposition to Catholic social teaching. While these combined influences proved too much for Dr Browne and his scheme, success was seen in the manner in which the Irish people saw clearly the systematic role of the church's hierarchy in influencing social policies in Ireland. This was to introduce a third overseeing party into the social contract already established between citizen and state, which, as evidenced by much of the public discourse in the media at the time, led many to, for the first time, begin to question the hegemony of the church and to seek justification for its involvement in their lives. Bacik (2013) suggests that the power the church exerts on areas of social policy in Ireland remains strong:

'The powerful influence of Catholicism thus continues to this day. The nature of the Church's role may be changing, and even reducing, but the Church continues to exert a strong influence on the everyday lives of all Irish citizens… In the areas of

education and health, in particular, the institutional Church continues to have great power, with both control by the Church and indirect subsidy of the Church by the state built into the structures of our education and health systems.' (p.19)

While Bacik's observation of the power of the Catholic Church in Ireland is an accurate truism, it begs the question of how it was that such a context of dominance was enabled. This thesis contributes to the answering of this very question and seeks to trace the genealogy of how the repeatedly stated obvious has come to be.

The dominant force of the 'free' market was instrumental in all of the genealogies of the previous chapter. The objections of the Irish Medical Association to the Mother and Child scheme can largely be traced to their interests as largely private businessmen fearing their private income to be at risk. While their objections were couched within the language of a moral and political objection to socialised medicine, their concerns were more commercial than they were philosophical. In the blood contamination scandal too the force of the minimally regulated free market in blood and blood products is unearthed at the very opening of the genealogy. But it is a thread of powerful influence that can be traced right back to the engaging of laissez faire ideology within social and economic policies. Ideology and power are inseparable as Bauman states:

> 'It is an undetachable part of the concept that any ideology is in somebody's interest; it is the rulers (the ruling class elites) who make their domination secure through ideological hegemony' (Bauman 2001, p.11).

However, as discussed in Chapter 3, classical liberal ideas that provide the ideological foundations of contemporary neoliberalism, have been largely misconceived and distorted into their contemporary forms. Even Adam Smith acknowledged that 'the market was not the preferred device for providing certain public goods' (Pellegrino 1999, p.261) as he believed that 'some things could not be left to the fortuitous workings of the marketplace and could only be assured by government intervention' (Pellegrino 1999, p.245). Pellegrino makes a well

structured argument that health care cannot and should not be considered as a commodity and warned of the danger of it being conceptualised in this way in the US environment of 'managed care':

> 'There is no room in a free market for the non-player, the person who can't "buy in" — the poor, the uninsured, the uninsurable. The special needs of the chronically ill, the disabled, infirm, aged, and the emotionally distressed are no longer valid claims to special attention. Rather, they are the occasion for higher premiums, more deductibles, or exclusion from enrolment. There is no economic justification for the extra time required to explain, counsel, comfort, and educate these patients and their families since these cost more than they return in revenue (Pellegrino 1999, p.253).

The strong, state-supported health insurance industry in Ireland constructed Susie Long as a non-player in the consumers' club of choice. As a result of her failure to engage in the market of private health insurance she became a 'failed consumer' and was what Bauman refers to as 'collateral damage':

> 'Collateral damages refer to the new frailty of inter-human bonds resulting from the transfer of consumerist patterns upon relations between humans. Collateral casualties of consumerism are all men and women affected by either of these and thereby confronted by a series of unfamiliar challenges difficult or impossible to cope with' (Bauman 2007, p.25).

Ultimately, despite the protestations of politicians and health executives after the death of Susie Long, the truly dominant force at play in her premature passing was that of the market. She, like those infected with contaminated blood, fell victim to the potency of market forces resulting in an injustice of fatal proportions. Farrell (2006) identifies the reshaping of the blood market as a consequence of market influences:
'By the end of the 1970s, the structure of the European blood market was changing. It was becoming a mixed public/private market whereby whole blood was sourced

predominantly from local voluntary, unpaid donors and blood products from a mixture of voluntary, unpaid as well as paid donors, both inside and outside Europe (p.156).

This shift in focus of the act of blood donation served to remove the essence of reciprocity in this epitome of a gifting relationship that Titmuss had argued was so precious. Instead of a gift relationship, increasingly a commercial relationship was instead entered into with a strong and powerful market involving paid donors and market forces. Berner (2007), however, attempts to suggest that Titmuss's influential work resulted in misplaced levels of confidence in the integrity of the blood donor and their donation, and that as a consequence the official response in some countries to the blood contamination issue was ineffective and delayed:

> '…the assumptive world of many health officials and doctors contained a firm view that existing blood collection practices were safe enough. The use of voluntary, non-paid donors was supposed to insulate the blood system from contamination. Donors were seen as altruistic providers of an almost sacred gift..' (Berner 2007, p.108)

An alternative perspective might be to say that had the blood transfusion services not turned to the markets in an effort to procure cheaper products, then the assumptions and confidence of officials in the supply might never have been misplaced. It was the act of relying on commercial engagements that served to render the gift corrupted.

The high levels of public confidence and regard for the medical profession in Ireland, garnered through their position of authority and power in society, are also likely to have influenced the events surrounding the blood contamination. Owing perhaps to their powerful positions as medical professionals, officials in the BTSB, it was revealed in the Tribunal many years later, had not seen it as beholden upon them to respond appropriately to warnings that might have removed the risk for future recipients. Such power may have served to corrupt some professionals to the point of arrogance, as was seen when Professor Temperley was questioned at the Lindsay tribunal about his public revelation at a conference of details of the HIV

positive status of patients before the patients themselves were informed. The power and influence of those in authority is also evidenced by the struggle that the victims of blood contamination were put through in order to seek the truth.

The vested interests of the medical profession, particularly those of hospital consultants, are clearly manifest in the genealogies of both the Health Insurance industry and, indirectly, in the story of Susie Long. The entire structure and system of Irish health care is so constructed as to advantage their interests and yet sustain inherent inequities. Hospital consultants have historically always opposed and 'resisted attempts to introduce a state medical service, salaried pay, and an equal playing field for treatment of all patients' (Burke 2010, p.30). Burke (2010) describes how 'inequality is inherent to the model of the Irish health system' (p.11) when she says:

> 'The Irish health services are structured on the basis of an unequal, complicated mix of public and private healthcare that produces cases like Susie Long, day in, day out (p.11).

She goes on to quote a Dublin hospital consultant, Dr Orla Hardiman who said:

> 'It is not a figment of imagination, there are hundreds and thousands of Susie Longs who can't go public. We are very grateful to her [Susie Long] for jettisoning her anonymity, for articulating the inequality in access to essential services for those who do not have private health insurance' (p.12).

The expansion of health insurance in Ireland in 1994 prioritised both the interests of the market, in terms of providing much sought-after competition and the interests of hospital consultants, particularly those with large private practices. Consultants in Ireland continue to enjoy positions of power by virtue of their role and, as Farmer (2005), put it in relation to doctors in the US, despite their technological abilities they 'allow not only the continuation but the entrenchment of inequalities' (p.173). Farmer goes on to challenge the medical profession and medical ethics for failing to demand equal access to care or to even make such issues the subject of their analysis. He

argues that when considering ethical dilemmas around technologies and clinical decisions, a great number of assumptions have been made:

> '..in working for the health of the poor, we are faced with a different set of moral issues. Will this patient get any treatment at all? Will her survival be considered less precious than a fourteen-dollar savings in basic medicines? These are not typical quandaries that the well-instructed medical ethicist can resolve by deciding when or where to flip a switch' (Farmer 2005, p.175).

The private health sector in Ireland continues to enjoy support from government policies in the form of incentives for the industry as well as incentives to the individual. These decisions in themselves indicate the prioritising of neoliberal ideas within Irish health and welfare and more generally the powerful position of the market in Irish social policies. The concept of choice is a core value of neoliberal policies and it is an effective distraction from the inequality of outcomes even in the presence of 'choice'. As Engelhardt and Rie put it, when referring to for-profit medicine in the US:

> 'Freedom of choice is valued more highly than equality of outcome, and …our commitments to beneficence are limited, as reflected by the absence of a constitutional right to receive welfare services' (Engelhardt & Rie 1988, p.1086)

The Irish citizen, cast as a consumer in a challenging market where health care is a commodity, is, if they engage in the market, being convinced by commercial rhetoric of their freedom to choose. Their choice might be which doctor to see, which private hospital to be treated in or which health insurance plan to purchase. Meanwhile, those outside of this realm, those who are unable to pay their way into having a choice, are left outside this club as they are cast instead as a failed consumer.

Welfare under Neoliberalism: what role for the state?

A recurring theme across the genealogies of the previous chapter is the contentious responsibilities of the welfare state under conditions of neoliberalism. As discussed extensively in Chapter 2, the welfare state is a highly contested field that has been subject to critique from numerous sources. However this analysis of these four specific narratives contributes to the discourse on the Irish welfare state and the role of the state in terms of its responsibilities to its citizens. It allows an examination of broader questions surrounding the beliefs and values of society as well as concepts such as the gift relationship, altruism and the social contract. To what extent does a social contract perform as a device that commands the state to provide for all members of society so as to compensate for the hazards of the market, or as a device to compound iniquitous social conditions? As discussed in Chapter 4, Rawls restates Kant's position of the social contract as 'a device which underpins his conception of a just society as a fair system of social cooperation between individuals who are free and equal' (Boucher & Kelly 1994, p.8). The extent of such freedom, equality, justice, fairness and social cooperation can be examined closely in an analysis of Irish genealogies of the previous chapter.

The genealogy of the contaminated blood scandal engages deeply with issues surrounding the welfare state, in particular its role as an honest, protecting and compensating entity. The role of truth is central to the narrative of the blood contamination, particularly in relation to the lengths that the victims of infection were forced to go to in order to learn the truth. Truth and veracity are key ethical principles often assumed to be features of a protective, supportive and compensating state, but this was found not to be the case in this genealogy. Warnings from a London hospital that products were contaminated were ignored by the BTSB leading to further infections and delays in treating those already infected and the report published after the tribunal of enquiry confirmed that BTSB staff had failed to act appropriately and face the consequences of their actions; a further example of an evasion of truth. The treatment of the infected citizens by a neglectful arm of the state depicts a failure to fulfil one side of a social compact.

But even before this point in this genealogy, the initial decision to seek blood products from outside of the state at a lower cost was in and of itself symbolic of a

poisoning of the altruistic gesture of the blood donor. Blood products imported from the US for example are largely sourced from US paid donors in some cases (Farrell 2012) and in other cases have been sourced from the vast US prison population. Titmuss argued that paid donors did not engage in a reciprocal arrangement that epitomised the gift relationship in voluntary blood donations. Furthermore, he argued that operating a paying market for blood donations 'greatly increased the risk of transmissible diseases to patient-recipients' (Farrell 2012, p.62). Awareness of the relevance of economic issues to blood safety is demonstrated by the commentary of O'Toole (2002) in the paper of record when he cites Prof Ian Temperley, the medical director of the National Haemophilia Treatment Centre, as having said in 1989:
'The board [BTSB] should understand that in the present period of financial stringency the hospitals could not be expected to meet a doubling of the cost of concentrates in 1989. Some balance will have to be struck between cost and the infection dangers associated with blood products' (O'Toole 2002, p.14)
It would appear that this balance was not made in the favour of patient safety, but instead in favour of cost containment.

The publicity and discourse surrounding Ireland's blood contamination succeeded in entirely sweeping away the levels of trust in public bodies such as the Blood Transfusion Board which had been built up through the many years of gifting of blood by citizens for fellow citizens. Furthermore, a role for market forces in the procurement of blood products resulted in a reversal of the relationship of forces placing the market in a position of power and authority. In this way, this case of blood contamination manifests as a transformative moment in Irish health care that created doubt where there had been trust, untruths where there had been veracity, and reckless negligence where accountability had previously been known. Further failure is seen in the case of Susie Long particularly in the manner that her story opened debate on the public's conceptions of the obligations of the state alongside the entitlements of the citizens. Here also market forces are revealed to have impacted on the scope of state provisions within the welfare state, revealing a broken social contract.

The welfare state is in fact in grave danger as a consequence of growing neoliberal hegemony. As Powell (2013) warns 'a global conservative restoration, called

neoliberalism, threatens to sweep equality and welfare away.[…] Neoliberalism […] has redefined civic virtue' (p.35). He goes on to state that efforts such as the Occupy movements 'represent the political face of radical global civil society challenging the neoliberal orthodoxy and its austerity agenda, designed to shrink the welfare state' (p.35). The shrunken Irish welfare state, as demonstrated in the case of health care received by Susie Long, met the criteria demanded by neoliberalism and minimal state intervention. In these conditions the state will only intervene as an absolute last resort but in this case, as with much in health care, last resort is too late. By the time Susie's case became a public issue her cancer had already spread and vital months of treatment had been lost. Her priority was to draw attention to the gross inequity in her story because it represented many others' stories whose voices were not heard. It cannot possibly be that nobody knew of this inequity, which to a large extent still persists.

Even if the average uninsured citizen was unaware that they were receiving inferiorly timed treatment, it is impossible to believe that those arranging, scheduling, and carrying out tests and treatments were not, or are not, patently aware of the discrepancies between the timelines of public and private patients, in what is best described as a broken social contract. Why these people do not speak up is a central concern of this thesis, relating as it does to the theme of 'acquiescence' or 'acceptance' leading to an absence of protest, and a question to which this chapter will return. Both the blood contamination and the Susie Long genealogies reveal the consequences when the market is relied upon as provider in situations regarding health, instead of a welfare state.

The failure to implement the Mother and Child Scheme provides further fuel to an examination of the role of the welfare state in Ireland. The chronology of this genealogy is interesting in that it takes place long before 'neoliberalism' has evolved but it still succeeds in demonstrating a time in Ireland when early capitalist ideas were emerging from early liberal developments. Certainly, the individual businessmen who largely made up the Irish Medical Association (IMA) had little doubt as to the extent of state involvement they were prepared to tolerate in the area of medical care for women and their children. The hierarchy's objections to this scheme while couched in the terminology of Catholic social teaching and

subsidiarity, also warned of the dangers of socialised medicine. The successful objections of the powerful interest groups of the church and the medical profession were clearly articulating a preference for a more minimalist state involvement and, on the part of the medics at least, a preference to give a more free rein to the market.

These preferences are clearly audible in the discourse surrounding the expansion of Ireland's health insurance industry from 1994 onwards. It is useful to be mindful of the precise origins of the VHI within the context of Ireland's overall health provisions. The VHI was originally put forward by the IMA as an alternative scheme to that proposed by the Health Bill of 1952, which sought to provide a by now much watered-down version of the mother and child service along with other provisions. Initially intended to provide health insurance for the top 15% of earners who would not qualify under the Health Bill's provisions, the VHI scheme grew incrementally over 40 years to the point of becoming a mark of status and success. In parallel to the growing status of respectable private insurance was an increasingly unfavourable attitude towards publicly funded care, which matched a strong neoliberal rhetoric of anti-welfarism. This discourse paved the way for state retrenchment of publicly funded care with little protest while means testing for eligibility for medical cards in Ireland still continued to become more stringent. Meanwhile the growing numbers of privately insured Irish served to encourage further subsidies to the private health insurance industries as well as individual tax refunds to the insured. This serves as further evidence of state subsidised individualism as was discussed in Chapter 2.

These four genealogies contribute to a very particular image of the influence of neoliberalism on the welfare state. While this contested field has been the subject of considerable social policy research over many decades, the Irish welfare state experiences neoliberal impacts in a particularly unique way. Fanning (2006) describes Ireland's mixed welfare economy as one wherein 'the balance of welfare provided by individuals for themselves and reciprocally for others has shifted towards a formal role for the state' (p.10) and he emphasises the increasing role for the state in regulating while welfare is provided by a mix of public, private, voluntary and informal sources; a balance he refers to as 'welfare pluralism' (p.10). This situation may not be as balanced as Fanning would suggest and certainly the proportion of

involvement between various sectors can be seen to be in a state of flux as the role of the private sector gains momentum induced as it is by state subsidies.

As a direct result of these shifts, the consequences for the condition of altruism and mutuality are, this thesis argues, highly significant. Mau (2004) refers to welfare state literature that emphasises this important role for the welfare state:

> '…the welfare state fosters a sense of mutual obligation through persuasion and moral argument. Hence welfare can be seen as an expression of altruism that is a part of people's sociability' (p. 56)

This secondary role of the welfare state in encouraging a positive moral interpretation of mutual obligations of reciprocity was underscored by Marshall (1975) who believed:

> '…the welfare state represents the final component of a set of rights, namely civil rights, political rights and social rights, and should be designed in such a way that it instils a sense of responsibility towards the welfare of the community. By granting equal status rights to all members of society and by eradicating social discrimination, the welfare state can (and should) create bonds of sympathy and shared responsibility among the citizens that prevent them from simply calculating the costs and benefits of certain welfare schemes (Mau 2004, p.56).

The Irish welfare state as seen through the genealogies in the previous chapter, is not one that models bonds of sympathy and shared responsibility and it can certainly be said that the dividing nature of the health system is not one that could possibly foster feelings of altruism. The state's seeming lack of commitment to societal solidarity is witnessed by subsidies to the private health insurance industry, by its embrace of market solutions to welfare problems and by its recognition of powerful actors in Ireland's health and welfare domains. Public attitudes to health systems and particularly the role of the state are thought to be influenced by normative value orientation as well as by direct or indirect experiences (Wendt et al. 2010).

Wendt et al. (2010) examined the relationship between social values and state provisions in their study of European health care systems and stated that:

> '…public attitudes towards state responsibility are, to a higher extent, guided by social value orientations and to a lower degree by own experiences with the existing institutional structure. In this vein, the generally high level of state involvement measured as a percentage of public funding seems to be in line with social values that are deeply embedded in European societies (p. 188)

This reciprocal relationship between social values of citizens and the social arrangements of the welfare state is an area deserving of further examination. Michailakis and Schirmer (2010) report that a similar relationship might exist between Swedish citizens' expectations of health and actual attribution of responsibilities. Examining the communicative structures that drive what they refer to as a marked 'shift from a collective responsibility of the welfare state towards individual responsibility' (p. 931) they argue that the political system has succeeded in rearranging the rights and obligations of the citizen and legitimise this through the changed expectations that evolve:

> 'The shifting attribution of responsibility is a communicative steering device the political system can make use of in order to keep control over increasing claims for medical treatment' (p.932).

Similarly functioning communicative devices can be seen to have been utilised in the Irish health care system and have succeeded in legitimising expectations of individual responsibility largely couched in the terminology of insurance against risks and combined with the notion of a degree of elitism. This can be seen in the discourse of popular media, as seen in the case of Health Insurance, and in the rhetoric of politics that seeks to explain away the shrinking obligations of the state. For example McDonnell and O'Donovan (2009) refer to the attempts in state discourses to laud private health insurance in Ireland:

> '…as embodying a unique cultural heritage founded on social commitments to community and intergenerational solidarity' (p. 6).

Not unlike the findings of Michailakas and Schirmer (2010), McDonnell and O'Donovan also point to the impact of communicative devices, particularly within Dáil debates, that served to blur the distinctions surrounding the meaning of 'community' and supported a myth of 'solidarity' among the privately insured, arguing that

> 'this myth has far-reaching consequences for how 'solidarity' is imagined, particularly given the pervasive pull of neo-liberal rationalities over the governance of healthcare' (p.7).

This 'pull' of neoliberalism is also referred to by MacGregor (2005) who identifies the source of such influence as being within the 'ideas, institutions and interests' that manifest as forces:

> '…selling the story that "there is no alternative". Alternative scenarios have been delegitimised. Dominant discourses play down state-centred solutions' (p.147).

The success of such discourses are evidenced in the numbers of privately insured in Ireland, the desperation of those languishing on underfunded public hospital waiting lists and the apathy and cynicism that accompanies much public debate on the role of the state under neoliberalism for the health and welfare of its citizens. These discourses have only been made possible as a result of key transformations, including the transformation of the citizen with rights and entitlements into an actor in the market, and also transformations in the understanding and conceptualising of the expectations and responsibilities of the welfare state. These transformations have resulted from an on going layering of discourses and concepts in a continuity that acts as a technique of power.

Conclusion

The analysis of these genealogies has provided evidence of a number of key findings that have been foregrounded here and the conclusions from which will be explored in the following chapter. Essentially, the objective was to explain how it is that Ireland's health and welfare system evolved into the deeply inequitable two-tiered arrangement that is currently in place. Through these chosen genealogies we can see the social, economic, political and discursive conditions that have made Ireland's current health care system possible and tolerated in its current form. These conditions have only become visible by virtue of the methodological approach employed in this research, as a Foucauldian genealogy serves to challenge and critique dominant assumptions, as well as to identify the discursive formations through which power is exercised. The discourses surrounding these stories and the message they relay about solidarity and individualism, about the value of a welfare state and about the role of powerful groups, have in some early cases served to lay the foundations of neoliberalism's success, while in other cases the discourses provided an accompanying normalising narrative.

This research has succeeded in identifying a number of key historical and residual factors that contribute to current conditions and has enabled identification of the precise modes by which these processes take place. Foremost in the findings is the fact that a number of hegemonic influences have combined to create the current conditions, and that their ideologies are legitimised through normalising, subjectivising discourses. The trajectory of establishment of these conditions has only been traceable through the use of a historical perspective that establishes the history of the present through an examination of 'the complex casual antecedents of a socio-intellectual reality' (Gutting 2003, p.12). The value of looking to history to explain and understand the present should never be underestimated. Historical events in Ireland have a long tradition of being kept alive in contemporary thought and, in many high profile cases, have resulted in long and complex historical tribunals of enquiry, as well as numerous attempts to provide redress for those hurt and neglected by past powers. Somers endorses the value of a historical genealogical perspective pointing out that: 'a history of the present rejects the conceit that it is possible to tell the past "as it was", independent of contemporary concerns' (Somers 2008, p.10). It is precisely such contemporary concerns

surrounding inequity and unfairness in Ireland's health care that prompted this examination of its genealogy.

A further, related finding worthy of attention is that the hegemony of neoliberalism sits obtusely as a dominant influence that features very strongly in the analysis of the genealogies and thus should be understood as contributing significantly to our comprehension of current health and welfare policies. The difficulty in identifying one universally recognised working definition of neoliberalism in itself points to the malleable nature of the ideology, as well as to the very decisive factor of the source of the definition. Its ability to assume different discursive forms (Phelan 2009) and indeed in many cases to exert its influence so as to control the discourse are crucial capabilities. Neoliberalism has only succeeded in the way that it has in Ireland's health and welfare domains because of the preparatory groundwork completed; work that involved promoting individualism, degrading the ideology of solidarity, devaluing the welfare state and, more crucially, persuading that there is no need for an alternative economic or social system. By virtue of its distinction as a hegemonic power, neoliberalism in many ways determines the very discourse that legitimises its own dominant ideology and establishes it as 'truth' (Phelan 2009).

Related to, and influenced by this normalising discourse of hegemonies is the standing of solidarity versus individualism in the contemporary Irish social world. The hegemony of neoliberalism and its legitimising discourse, has succeeded in eroding conceptions of the value of solidarity and dismisses communitarianism in favour of the individual. With significant contribution from neoliberal reportage and critique in public and media discourses, the ideological centring of individualism that rewards self reliance and invokes responsibilisation, has succeeded in devaluing and, in some cases, demonising collective action and with it solidarity and altruism. As a consequence, appreciation of core philosophical and socially binding concepts such as the gift relationship are eroded. A socially divided and individualised society has emerged. Solidarity assumes and requires the presence of an 'other' who shares the context of the issue, one with like-minded views and the abilities, social skills and resources to organise. To proceed with a sense of fellowship or fraternity in these circumstances, where economic relations are valued over social relations, becomes inconceivable.

The final finding of note here is that of interpretations of the role of the state in supporting the citizen and particularly the positioning of the social contract relationship within the context of capitalism. It is clear that capitalist states are 'fundamentally concerned with the maintenance and reproduction of capitalist social relations' (Ginsburg 1979, p.2) more so than they are concerned with maintaining the social relations inherent in a social democratic welfare state. It is argued therefore that whereas in the past the state's welfarist role was to compensate for social ills that it largely had no part in creating, current capitalist states in fact are responsible for many of the difficulties that have beset their citizens as a consequence of their government's neoliberal policy agenda.

The following chapter will take these core findings and map them against the powerful and significant social and theoretical concepts that were explicated in Chapter 4. Additionally, the outcome of the analysis within this chapter will be distilled further within the context of the wide literature surrounding the welfare state, as well as the body of knowledge (and opinions) related to neoliberalism, both of which were examined thoroughly in the earlier Chapters 2 & 3. A systematic revisiting of this literature in the light of the analysis of the genealogies it will make evident the conclusions that can be derived from this research. Combined, this layering of deliberation provides a unique understanding of the constellation of historical, political and economic factors that have framed the condition of Ireland's health system and welfare state.

Chapter 8: Conclusion

Introduction

This final chapter brings together the findings discussed in the previous analysis chapter, as well as aspects of the theoretical literature explored in Chapter 4, in order to create a concluding summary of the thesis. In so doing, a wider and more abstract perspective is taken that initially moves out from the specificities of the genealogies, and indeed from the case of Irish health and welfare, concentrating instead on the wider implications of the research and its findings from a theoretical and conceptual perspective, reflecting on the effectiveness of the genealogical method employed.

Effectiveness of the Genealogical Approach

A pivotal intention of this research was to utilise a historical approach, informed by Foucault, which would actively interrogate current circumstances through an examination of the past. There is a danger that contemporary concerns with the constant progress of modernity could result in an inability to look in any other direction other than to the future. A full and critical perspective on the past, a history of the present, is vital if we are to fully understand our current complex conditions. The renowned historian Eric Hobsbawm expresses concerns about our ability to look to history so as to inform our present when he says:

> 'The destruction of the past, or rather of the social mechanisms that link one's contemporary experience to that of earlier generations, is one of the most characteristic and eerie phenomena of the late twentieth century' (Hobsbawm 1994, p.3).

Hobsbawm's observation of this phenomenon is an astute one, and one that relates to a reluctance to consider an earlier influence on the origins of our contemporary human experiences. Foucault regarded history as 'the articulation of the series of practices […] that accounts for our current practices' (Flynn 2003, p.40). It is, therefore the capacity to articulate current practices through past practices that

makes the historical perspective, as utilised in this thesis, immensely purposeful. More specifically, the genealogical approach has been shown to be most appropriate due to its effectiveness in the context of issues of power with which Foucault became so concerned on his genealogical turn (Paras 2006). Foucault's genealogical approach, as explored in Chapter 5, confronts the past 'in the full knowledge that every "eternal truth" is a violently imposed interpretation' (Paras 2006, p.53) and, as has been seen in this thesis, these violently imposed interpretations are crucial to how social phenomena are seen, understood and tolerated. Habermas endorses the approach taken by Foucault in his microanalysis of power, specifically the manner in which it:

> 'calls our attention to an invisible dialectic between the egalitarian tendencies of the age and those new unfreedoms that settle into the pores of simultaneously emancipated and systematically distorted communicative practices' (Habermas & Pensky 1994, p.119).

Again, we can see the unsettling role of genealogy in uncovering and making visible hidden knowledge and the subsequent use of such knowledge to challenge what is taken for granted. Foucault emphasised this feature of genealogy when he described it as:

> 'the union of erudite knowledge and local memories which allows us to establish a historical knowledge of struggles and to make use of this knowledge tactically today' (Foucault 1980, p.83).

The nature of the powerful influences that have shaped Ireland's contemporary health and welfare system have been exposed in this thesis by virtue of the methodological approach used. This method succeeds because it:

> '…unsettles the seeming naturalness and necessity of our epistemic perceptions […] by showing the historical construction of the underlying conventions of our perception' (Owen 1999, p.594)

It is precisely the underlying assumptions and conventions that were the site of examination in this research, as they in themselves are sites of powerful disciplinary struggles. Such an examination is vital so as to disrupt and challenge the positioning of assumed, adopted and embedded beliefs, foundational to our current complex situation and assumed to be immutable. ('We are where we are'; 'There is no alternative')
Foucault's examination is similarly disruptive as:

> '…Instruments of a critical enquiry that sheds light on given historically contingent events, without pretence that they refer to foundational or universal structures that govern the formation of human thought and/or practice'

The wide-scale of assumptions about the permanency of the current state of many social arrangements in capitalist economies, including that of Ireland's health and welfare systems, can be traced back along a history of 'ramifying ancestors' (Geuss 2001 p.x). The job of work of such a critical enquiry, as has been attempted in this thesis, is to demonstrate the impermanency of the phenomenon that has become so embedded. This approach requires the acknowledgement of history and:

> 'A past that still constitutes an effective part of the reality of the present, not a closed, "dead" past. History is a continuing series of transformations in which the old is not simply obliterated and utterly deleted but is taken up and preserved in a modified form' (Geuss 2001 p.xii).

The historical perspective, therefore, acknowledges the vitality of antecedent circumstances such as those examined in the case studies. The unveiling quality of this perspective thus enables a clearer understanding of the matrix of powerful influences and intricate distinct contexts that have brought forth the present complex realities.

Drawing Conclusions

This thesis serves as a genealogy of the development of a complex policy paradigm wherein the social contract is no longer held as central, and where solidarity is outflanked by individualism. Furthermore, efforts to corrupt the gift relationship as a totalising social fact, contribute to a complex matrix, which this thesis has sought to explicate. This intricate paradigm is firmly rooted in the tradition of neoliberalism with its own roots in the ideologies of classical liberalism. The success of the paradigm can be accounted for by the manner in which neoliberal social and economic policies have proliferated, and by the way that neoliberalism has become the assumed modus operandi in contemporary capitalist economies. Such policies and ideological approaches, narrated in the case studies/genealogies of Chapter 6, run counter to the objectives of any true welfare state, other than the deeply residual type, and consequently, an antipathy exists between neoliberalism and welfarism. A historical perspective on this tension demonstrates that this was not always the case.

Before the emergence of near total capitalism an alternative ideology was predominant. Ginsburg (1979) reminds us of this time stating that:

> '…the welfare state is conceived within the predominant ideology as a historic act of collective altruism, which serves to integrate the citizen into society and to meet his/her needs as they are recognised by the collectivity' (p.40).

The original intentions of Beveridge when conceiving of the original welfare state was clearly to alleviate want in the presence of capitalism:

> '…giving security against all the main risks of economic life to those who depend on continuous earning […] whenever their work is interrupted or stopped by causes beyond their control. This is the line of social insurance, maintaining individual freedom and responsibilities and the family as the unit of the State' (Beveridge 1924, p.31).

And he was equally clear on the need for this service to be freely available:

> '…A health service providing full preventive and curative treatment of every kind to every citizen without exceptions, without remuneration limit and without an economic barrier at any point to delay recourse to it, is the ideal plan' (Beveridge 1942 part VI, p. 437).

Importantly though, the perspective of liberal collectivists, even then, was that while a welfare state was desirable, state intervention would be minimal and that there 'should be as little interference as possible with the valuable political and economic freedoms of capitalism' (Williams & Williams 1987, p.10).

Because this minimalist approach to welfare endures, and has become more embedded, it is increasingly challenging to conceptualise the strength and depth of altruism and social solidarity that accompanied the true welfare society that was envisaged for the UK by Beveridge and endorsed later by Titmuss, for example, who was:

> '…genuinely concerned with the pursuit of humanitarian, even egalitarian, values, and a history built up from Shaftsbury and Booth, through Lloyd George and Beveridge, and which is expressed at its best in Titmuss's altruistic NHS' (Barker & Askham 2004, p.116).

Whereas at the conception of the welfare state a key role of the state was to compensate for social ills that emerged as a result of capitalism, current residual welfare states struggle to mitigate the negative effects resulting from the policies of that same state. The welfare state can be seen therefore as 'a principal institution in the construction of different models of post-war capitalism' within what Esping-Andersen refers to as Welfare Capitalism (1990, p.5).

The predominant rhetoric of the virtues of being a responsible, self-fulfilling citizen who rejects dependence on others can be seen to have evolved alongside the embedding of neoliberalism. It is these 'increasingly pervasive notions of individualism, markets and marketability', say Brown and Baker (2012), that have manifested as a 'cultural rubric' and are 'the key legacies of neoliberalism' (p.18).

The neoliberal ideology has been unquestioningly adopted to the extent that responsibility for the recent economic crises, for example, is not seen as resulting directly from the adoption of neoliberalism itself as an economic model. Moreover, as Mirowski (2013) suggests, neoliberalism has not only survived the crisis but has, as an efficient thought collective, succeeded in outmanoeuvring the left so that only a neoliberal account of the economic crisis is heard; one that defines the crisis in neoliberal terms. As Mac Gregor (2005) states:

> 'At present, many forces are selling the story that "there is no alternative". Alternative scenarios have been delegitimised. Dominant discourses play down state-centred solutions. Urgently, a new battle of ideas is needed to argue for progressive reform' (p.147).

A challenging call for an alternative conception of the citizen has also been made by the President of Ireland, Michael D. Higgins, in his address to the European Parliament (Higgins 2013b) when he appealed to the European Parliament not to:
'ignore the fact that European citizens are suffering the consequences of actions and opinions of bodies such as rating agencies, which, unlike Parliaments, are unaccountable. Many of our citizens in Europe regard the response to the crisis in their lives as disparate, sometimes delayed, not equal to the urgency of the task and showing insufficient solidarity with them in their threatened or actual economic circumstances'.

He goes on to challenge the dominant concerns with economic matters and he makes an impassioned plea for an alternative approach when he suggests that the:
'Economic narrative of recent years has been driven by dry technical concerns; for example, by calculations that are abstract and not drawn from real problems, geared primarily by a consideration of the impact of such measures on speculative markets, rather than driven by sufficient compassion and empathy with the predicament of European citizens who are members of a union, and for whom all of the resources of Europe's capacity, political, social, economic and intellectual might have been drawn on, driven by the binding moral spirit of a union'

Subjectivised through language and discourse

A marker of the 'success' of neoliberalism that is demonstrated in this thesis, is evident from the manner in which its language and rhetoric have become popularised and normalised into realms of the social sphere far removed from the ideologies on which neoliberalism is founded. The business model that is increasingly being implemented in health care serves as an example of this wherein the patient is referred to as a client, their need for health care defined as the purchasing and consumption of a service, while personal human conduct is increasingly seen as a market commodity (Brown & Baker 2012). Furthermore, despite the failure of neoliberalism across numerous capitalist economies, neoliberal globalisation continues to spread to unsuspecting less developed countries who, as a consequence of economic violence, corruption, subversion and war (Dumenil & Levy 2011) risk the pillaging of their natural and human resources.

While neoliberal explanations achieve dominance and acceptance, crowded out from public discourse is the alternative explanation that engages the philosophical concepts of the social contract, of the gift relationship, solidarity and of rights-based citizenship. Somers (2008, p.1) warns that, 'the ability of civil society, the public sphere, and the social state to exert countervailing force against the corrosive effects of market-driven governance' is critical to ensure regimes of democratic and inclusive citizenship. However, by virtue of its hegemonic status, neoliberalism obliterates the intellectual and critical capacities of citizens to conceptualise any alternative strategy relying as it does on the potent force of individualisation. Neoliberalism's dependence on the divisiveness of its individualism has been effectively illustrated in some of the genealogies employed in this thesis.

The process of individualisation not only fits with the neoliberal paradigm in terms of the minimising of state responsibilities, but it also serves to disable any potential for collectivism or solidarity which might serve to create the countervailing force to which Somers (2008) refers. Thus the hegemonic qualities achieved by neoliberalism, and revealed by the genealogies in this thesis, fit well with Gramsci's description of a hegemony, which he said:

> '…necessarily supposes an intellectual unity and an ethic in conformity with a conception of reality that has gone beyond common sense (Gramsci 1971, pp.333-4).

Through the hegemony of neoliberalism we have not only lost our ability to challenge and question the assumed ideology, but we have, as citizens, become reformulated as subjects in a market. Brown and Baker (2012) illustrate this process using Bourdieu's (1998) terminology to explain how neoliberalism:

> '…encourages a reconceptualization of society and social life that theoretically and frequently in practice moves closer and closer to an idealised image of a free market based on a "individualist micro-economic model"' (p.10).

Within this free market, the subjectivised citizen emerges, Foucault argues, as 'the product of highly rationalised discursive systems […] the effect of a modern configuration of power' (Paras 2006, p.103). The subjectivised citizen is clearly revealed through the genealogical case studies within this thesis, which serve as exemplars of similar reformulations that are being played out in countless events and contingencies in the lives of citizens under neoliberal hegemony. However, Laclau and Mouffe (2001) emphasise that, 'every hegemonic position is based on an unstable equilibrium' (p.189) suggesting a potential for volatility. Neoliberal hegemony, unlike the gift relationship, does not constitute a total social fact.

In many ways, MacPherson (1962) had foretold much of what was to follow in late capitalism and his political theory of Possessive Individualism was somewhat prophetic, as can be seen with contemporary responsibilisation of citizens in relation to health. When conceptualised within a market, Macpherson warned that the 'best' society:

> 'is one in which all social relations are transformed into market relations, in which men are related to each other as possessors of their own capacities' (Macpherson 1973, p.193).

Macpherson warned that 'the assumptions of possessive individualism (though now ethically inadequate) are still factually accurate' (p.158). And yet, despite the ethical inadequacy of market-dominated societies, the assumptions of possessive individualism now permeate most aspects of human existence under capitalism, and have resulted in a formulation of human relations where individuals are located, competitively, as subordinate to the laws of the market. Such a formulation exhibits some self-perpetuating features which Townshend (2000) alludes to when he warns of grave social consequences if we:

> '…continue to see ourselves as "infinite" consumers and appropriators - in short as possessive individualists - if we continue to embrace an ideology functional to the capitalist market' (p.viii).

A reformulated citizen is necessary to sustain the capitalist project primarily because: 'Human beings are not, by nature possessive individuals, but this is the sort of human being that capitalism requires and, to a large extent, produces' (Carens 1993, p.4)

In the context of global hegemonic neoliberalism, and capitalist market-driven human relations then, what happens to the critical philosophical conceptions that are at the core of this research? What of the social contract, the gift relationship and solidarity? This thesis argues for a continued role, albeit an embattled one, for these critical concepts in the maintenance of a humane civil society wherein values other than those of the market must be seen to endure.

Rescuing solidarity, altruism and the gift relationship through a renewed social contract.

The exploitation of the original intentions of classical liberalism, and the resultant extensive neoliberal hegemony, has created an exceptional situation that runs counter to many human intuitive and instinctive perceptions of an obligation to support those who are sicker, weaker or more vulnerable. The principles on which Mauss stated that a debt ought to be paid to the worker by society would appear to have become corrupted:

> 'The state itself, representing the community, owes him, as do his employers, together with some assistance from himself, a certain security in life, against unemployment, sickness, old age and death' (Mauss 1990, p.86).

We have instead, it could be argued, reached a historically unprecedented level of subjectivity. As Douglas (1990) warns: 'Solidarity has again become a central topic in political philosophy. Social Darwinism walks again and the survival of the fittest is openly invoked' (p.xxi). The subject in this pure market society has become transformed and what we do not know is whether it is still possible to appeal to that transformed subject.

This thesis contributes to this question by bringing together a number of exemplars of the influences and contexts, through which the creation of current conditions are portrayed, as well as the consequences when the social contract is reduced to a market contract. Through this process it is possible to identify the point at which a market contract, for all its apparent objective features, breaks down into something less humane and more socially unjust.

A Complex Reality

The two broad core findings of this research, with their respective related sub-themes, demonstrate the deep complexity of the Irish case that was the subject of this thesis. The exemplary case studies that were examined in Chapter 6, demonstrate the elaborate nexus of interrelated factors that are at play in the Irish case of health and welfare. The role of a powerful medical profession proved to have been influential in a number of the cases, as was that of the church, particularly in the case of the Mother & Child Scheme, and effectively in the entire history of Irish health and welfare policy. When added to this mix of potent influence, market forces within a neoliberal context, culminates in conditions wherein the role of the state in a social contract is called into question.

The discourse surrounding all of these associated factors provides a rich tapestry wherein issues of solidarity and individualism are played out and normalised within

the public sphere. Ireland's status as a complex mixed model of welfare provides the backdrop for the realisation of acquiescence through the layering of a normalising discourse.

Furthermore, this work enables a historical perspective on these core concepts within the context of Ireland's health care; a domain that is arguably within the interest of all members of civil society and largely under-theorised. By portraying the vital role of these critical concepts, and the human consequences of their erosion, this thesis furnishes the debate within contemporary studies of the social with a unique opportunity to make these philosophical concepts relevant. That is to say, the true and brutish ramifications of the unquestioning passage of ideologies that neglect the social contract and thereby erode levels of solidarism into the domains of health and welfare, can be visualised, identified and emphasised.

Paradoxically, this strategy appeals to the individualised subject who may be entreated to consider the consequences for themselves, if not empathetically for the broader civil society. A preferable strategy, though, is one wherein the principle of solidarity might serve as a core driving force. Durkheim's work references this paradoxical situation as he believed that individual autonomy 'could only be attained upon secure foundations in conditions of social solidarity firmly binding its members to each other' (Coser 1984 p.xiii). The benefits of such organic solidarity, Durkheim believed, include greater societal cohesion and a level of social integration that would be fostered by interdependency. The deconstruction of the welfare state, that was intended to encourage such interdependency, achieves the precise opposite of this and consequently erodes solidarity.

There is, however, some evidence that demonstrates a residual potential to appeal to deeply held intuitive conceptions, which may not yet have been obliterated by the rhetoric of individualisation and self-responsibilisation and instead to seek a reinvestment in the collective. The contemporary challenge therefore is to re-establish a capacity for solidarity and altruism not just in spite of, but because of, these dominant relations of power with which the market society is populated. Sites of dominance must be articulated as such and participation in discourse must seek to make equal the opportunity for truth claims where conflicts emerge. Such a

transition requires a shift away from the individualised society and a revaluing of relationships other than those based on a market. A new sustainable social contract must be formulated in which the state, recognising the value of real and participatory citizenship de-subjectivises its citizens.

Societal demands for transparent and equitable attainment of a robust social contract, will require a change in conceptions of the nature of the relationship between citizen and state. The core principles around which this thesis centres, the social contract, the gift relationship, solidarity and possessive individualism can be seen to be central to such a reconceptualisation. An argument must be constructed that demonstrates a strong role for these core ideological principles to be maintained and redeemed as crucial elements of any social institutions including a health and welfare state. To reinvest in the collective in the face of ardent individualism requires altered conceptions of the value of a genuine social contract; a reshaping which is challenged by embedded, subjectivised, possessive social relationships. The challenge is for social policy to re-articulate the ideals of the social contract and the gift relationship despite the context of neoliberalism and gross market dominance, appealing to an inherent capacity for organised organic solidarity.

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